

STREET PEOPLE

HEARING
BEFORE A
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COMMITTEE ON APPROPRIATIONS
UNITED STATES SENATE
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FIRST SESSION
SPECIAL HEARING

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STREET PEOPLE

MONDAY, JANUARY 24, 1983

U.S. SENATE,
SUBCOMMITTEE ON THE DISTRICT OF COLUMBIA,
COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 10:35 a.m., in room SD-192, Dirksen Senate Office Building, Hon. Arlen Specter (chairman) presiding.
Present: Senator Specter.

NONDEPARTMENTAL WITNESSES

OPENING STATEMENT OF SENATOR SPECTER

Senator SPECTER. Good morning, ladies and gentlemen.

This hearing of the D.C. Subcommittee of the Appropriations Committee will proceed at this time on the subject of the "street people," sometimes referred to as "bag ladies" or "grate people."

The purpose of this hearing is to examine this problem which seems to be increasing in the major metropolitan areas. Who are these people and where do they come from?

The aspect on which this committee would like to focus is homelessness. Its problems are rooted in many causes, among them lack of low cost housing, displacement, unemployment, reduction in social services, and the deinstitutionalization of mental hospitals. The news media reports of the morning are replete with up to the minute reminders of the problem. The metropolitan section of the Washington Post this morning carried a story entitled "Freddie dies." It is the story of a street person in Washington. This morning, the Philadelphia Inquirer on the first page has a reference to New York City, a city straining in an attempt to house more homeless and noting that in the last week there were nearly 5,000 men and women who were seeking homes, the greatest number since the depression. And the New York Times, this morning, has on its front page a similar story saying city braces for price of sheltering homeless families and low rents.

As anyone travels around the streets of the city, Washington, D.C., even as you were coming here this morning, you saw people deriving their heat and their sustenance from the heating apparatus on the street vents. We are going to take a look at this problem to see what might be appropriate to the District of Columbia or perhaps on a broader basis

what might be available to the Subcommittee on Health and Human Services in terms of what might we do with it.

STATEMENT OF HON. STEWART B. M'KINNEY

Our lead witness this morning was supposed to have been Congressman Stewart McKinney, ranking minority on the Committee on the District, the House of Representatives. Congressman McKinney has the fortune, good or bad, to have missed a plane so he is in Florida where I understand the weather has not been too good either.

[The statement follows:]

STATEMENT OF HON. STEWART B. MCKINNEY

Mr. Chairman, I strongly endorse the compassionate aspirations and the humane objectives of the deinstitutionalization movement. I do so in the belief that, where feasible, community care is the most proper and decent form of treatment for the mentally ill.

However, upon examination of the current status of community care facilities and programs in the District of Columbia, in my home state of Connecticut, and nationwide, it is evident that the implementation of our original deinstitutionalization goals has been a failure at best. The serious lack of progress is causing undue hardship, unnecessary injury, and tragic death.

The appalling lack of community treatment facilities is the primary cause of current deinstitutionalization problems. As a result of federal financial incentives, rapid discharges of patients from public mental hospitals into the community took place between 1955 and 1980. This trend resulted in a 70-percent reduction in the number of residents, from 557,000 to 150,000, at State hospitals.

In Connecticut, the census of State hospitals shrank from 9,000 in 1954 to 3,000 in 1975. Unfortunately, Mr. Chairman, the broad spectrum of community services needed to suitably care for the newly discharged patients was not established. As a result innocent patients were exposed to a lonely experience in the "real world".

For instance, a 1981 report by the Community Service Society of New York, entitled *Private Lives/Public Places*, estimates there are 36,000 homeless men and women in New York City, the majority of whom are chronically mentally disabled. In addition, *Life* magazine estimates a quarter of a million people nationwide are "without supervision, structure, or assistance." These are shocking statistics, graphically reflective of the problems we face today. In addition, a 1977 General Accounting Office report on the mentally disabled stated:

"Many mentally disabled persons have been released from institutions before sufficient community services and facilities were available and without adequate planning and follow-up."

While many mentally ill persons have been released from institutions and placed in group homes, foster care homes, and provided with comprehensive services, others have not fared as well. The GAO report described many

community residences^{nces} as "overcrowded, substandard, and dirty facilities, without provision being made for needed services."

The lack of proper community care has resulted in a significant increase in the readmission rate of State hospitals. A 1978 Scientific American article reported that: "Admissions to State hospitals increased from 178,000 in 1955 to a peak of 390,000 in 1972 and had declined to only 374,000 by 1974:

Moreover, "A growing proportion of these admissions were readmissions with about one-half of the released patients readmitted within a year of discharge.

This readmission syndrome is poignantly demonstrated by Jeanne Farrell, Commissioner of Social Services for the Town of Greenwich. Miss Farrells writes:

"Sam is 26. He's been in and out of mental hospitals since he was 16. He's a floater, has no skills, no family, no income, no home. Several weeks ago the State hospital called. Sam had readmitted himself, was considered for the Alcoholic Unit but rejected. The reason? He needed long-term treatment and, as the theory of deinstitutionalization goes. Sam's community should provide this care. Sam was put on a bus for Greenwich. No plan. No money. He ended up on welfare at a commercial boarding house in a nearby town with an assortment of drug addicts, ex-convicts and other social 'misfits'.

"He came to see us on Christmas Eve and asked to be sent to Boston to stay with friends. We called Boston and then we put Sam on a train. He hasn't been seen since."

Finally, in Nebraska, 12 patients have been released and readmitted a total of 127 times, and one patient has been readmitted 27 times. I point this out only to illustrate the severe lack of a coordinated, comprehensive, and effective national deinstitutionalization policy.

Finally, the use of nursing homes has in effect transferred patients, not to a community treatment setting, but from one form of institutionalization to another. The National Center for Health Statistics showed a 48 percent increase in the number of nursing home residents with mental disabilities from 1969 to 1977. In Connecticut alone, over 3,000 former mental patients live in nursing homes. For many, these homes show little improvement over the State hospitals from which they were discharged.

This movement from hospitals to nursing homes is called transinstitutionalization, meaning patients have gone from one institution to another. I should point out

this movement from institution to nursing home cuts the State's financial responsibility in half.

In addition, a study by the Department of Health and Human Services concluded "more than 50 percent of the nursing home residents were in facilities with 100 beds or more and about 15 percent were in facilities of 200 beds or more."

Furthermore, nursing homes are often not equipped to treat mentally ill patients. The 1977 GAO report stated:

"Many of these are not staffed or prepared to handle the developmental or psychiatric needs of the mentally disabled. Some did not meet safety or patient care standards. Some were so large that, in effect, persons were moved from one institution to another." The result of this policy is not community rehabilitation as was embodied in the original goals of deinstitutionalization, but another form of custodial environment with substandard levels of care.

Clearly, it is time to examine new approaches to caring for the mentally ill. We can no longer afford to rely on one macro solution, such as complete deinstitutionalization, or complete institutionalization.

How and where patients are treated should not be determined by politicians or administrators but rather by those most knowledgeable to make these crucial decisions, mental health professionals.

Dr. Jonathan F. Borus makes my point quite eloquently in the August edition of the New England Journal of Medicine:

To clinicians, it is obvious that patients with chronic mental disorders have substantive illnesses requiring diverse treatment and support services in both the hospital and the community. Clearly, the choice of care should be determined by the clinician's treatment decisions about individual patients rather than by political policy that indiscriminately dictates any single alternative.

With this in mind, we must address the misconceptions surrounding deinstitutionalization if we are to improve the mental health delivery system.

First, is the prejudice against hospitalization still valid? The experience of the past decade indicates that some patients continue to need mental hospital settings because of the severity of their behavioral disorders. Such violent, incompetent, or suicidal patients find community survival traumatic and are

unsuited for general hospital or community mental health center inpatient services.

Without the availability of mental hospitals as a backup for chronically mentally ill patients the pressure on general hospitals to free up beds results in unusually high hospital readmission rates.

Second, it is a myth to imply that deinstitutionalization will save money. The fact is that State mental health budgets have increased over the past decade with inflation and with the dual responsibility of maintaining both State hospitals and community facilities.

For example, a cost/benefit study by the University of Wisconsin concludes that running a network of State hospitals is almost always cheaper than providing community care. In addition, Dr. Robert Okin, who recently served as the Massachusetts Commissioner of Mental Health, estimates that if properly carried out it will cost twice as much to treat patients outside hospitals than in.

Since 1963 States have pushed community care because they can shift the fiscal burden onto the Federal Government. This "buck passing" by the States is fast coming to a close with the shrinking Federal fiscal commitment. More of the fiscal burden than ever will fall on the States and local communities.

Mr. Chairman, these figures are not offered to suggest an abandonment of our deinstitutionalization goals. Where appropriate and pragmatic, deinstitutionalization represents the best possible care for the mentally ill. However, premature implementation of total deinstitutionalization is irresponsible, immoral, and a disservice to those it intends to serve.

My goal is to allow specific treatment for an individual to be determined, not on the basis of ideology, but according to that individual's need for services as determined by mental health clinicians. With this in mind, we must act to restore the option of using State hospitals when community facilities are not available.

This option, if not the most desirable, is certainly more humane than allowing the mentally ill to be released to a life of tragic loneliness, cruel inhumanity, and frequently undignified death.

COMMUNITY FOR CREATIVE NONVIOLENCE

STATEMENT OF MITCH SNYDER, DIRECTOR

Senator SPECTER. We will move ahead now with Mr. Mitch Snyder, who has some unusual insights into the problems of the street people. Mr. Snyder is a man who has lived on the streets himself; he has certain experiences with the criminal justice system which he may choose to share with us. He has written extensively on this subject and we welcome you Mr. Snyder for whatever insights you can present to us on this complex subject.

We have received your statement. It will be made a part of the record in full and we would be pleased to hear the highlights of your testimony.

Mr. SNYDER. I have a very brief prepared statement. I do not like the prepared statements, but it was suggested that it might be appropriate and somewhat respectful use of the Chair's time.

I would then invite you to ask any questions that you want.

We live in a disposable society, a throwaway culture. The homeless—particularly the physically and mentally disabled—are our human refuse, remnants of a culture that assigns a pathologically high value to independence and productivity. America is a land where you are what you consume and produce. The homeless are simply surplus souls in a system firmly rooted in competition and self-interest in which only the "strongest"—that is, those who fit most snugly within the confines of a purely arbitrary norm—will survive.

Who lives on our streets and in our back alleys? Those who for a number of reasons silently plummet through changes of circumstance with no hand to grab, until they finally, and quickly, hit bottom. Some are senile, others alcoholic. Many are unemployed. Some are the physically disabled. All share equally in the democracy that is poverty: bodies broken, spirits equally disfigured.

There are the ex-mental patients, comprising one-third to one-half of the homeless population, both locally and nationally. Not at all difficult to spot, they are the muttering, puttering souls, pockets and shopping bags bulging with all of their worldly possessions. They are living testimony to the abysmal failure of deinstitutionalization.

What is it like to live on the street? It is as though two separate realities exist. For the homeless, the rest of the world is alien and irrelevant. The "housed" ones share none of the homeless' concerns or priorities. Their hopes and fears, their expectations and their frustrations bear little or no resemblance to our own.

Driven by they know not what, the homeless are always on the move; looking for food, clothing, shelter, work. They search endlessly for all the prerequisites and necessities of life, constantly running and hiding from the voice on high which decrees "You don't belong here. You don't belong. You there! Don't be long! Move on! Move on!"

To live on the street is to descend into hell. There is nothing to equal the indignity and sheer animal horror of homelessness. That we allow our helpless citizens to live and die in this way, cast out and alone, is

revolting, enough to render a human being forever speechless with pity and disgust.

Senator SPECTER. Mr. Snyder, I understand that you are the director of a successful program that does help street people.

How does your program function?

Mr. SNYDER. Well, actually we are a nonhierarchical community so we have no director—I am simply a member. For the last 11 years, we have been providing food, clothing, medical care, emergency shelter, facilities where people can wash their clothes, clean up, sit down, and rest for a little while. Right now we are feeding somewhere between 1,000 and 1,500 people a day. A few days back, we opened an emergency shelter large enough for 500 men, women, and children in the Southeast section of the city where there has never been a shelter.

We do what we do in a very centralized, very volunteer oriented way. We believe that institutional settings and institutions that are staffed by folks for whom it is a job rather than a vocation, tend to create an atmosphere which is both dehumanizing and tends to maintain the poverty or the problems that it addresses so we rely very heavily on volunteers. We are all volunteers. There are about 25 to 30 members of our community that work full-time for free, sharing in the bounty or lack thereof of the folks that we serve. Our food comes out of the trash. It is unsellable but perfectly usable. The clothing that we distribute is either cast off or comes from dry cleaners, other places where clothing has been unclaimed, can be made use of. We do that not with a sense of offering charity because we do not like charity. We think charity is debilitating, dehumanizing, and it tends to break down the dignity and the worth of the individual, relegating them forever to a position of inferiority and subservient.

We do what we do because we believe every human being, by virtue of their birth, regardless of color, religion, creed, sex or any other factor, is entitled to shelter, clothing, food, medical care, a decent education, an opportunity to continue as best they can to the environment of which they are a part.

So that is the spirit that we bring to our work and we do it day in and day out. We have not missed a meal in 11 years. We do not intend to. It is a lot of folks relying upon us for the services that we do provide.

At the same time, we have another side to our community and that is the side that confronts what we believe are values and programs and prospectives and priorities that are themselves destructive, and they produce the victims that line up at our soup kitchens and not on our shelter doors and beg us for a pair of shoes in the winter or an overcoat, something that will keep them alive. We confront those values and those institutions because we see the two, the service of one's neighbor and the rooting out of injustice and evil as responsibilities born of citizens.

Senator SPECTER. You say you feed 1,000 to 1,500 people a day?

Mr. SNYDER. That is right.

Senator SPECTER. Would you have an estimate as to how many street people there are in Washington, D.C.?

Mr. SNYDER. We estimate a minimum of 5,000 to 10,000 people.

As you well know, there has been a lot of debate over the past 3 years on that question. Many people have many estimates. No one can state with absolute certainty how many people there are. But, to the best of our knowledge and based on personal relationships, and 11 years of working, living with the folks on the street, we would say it cannot be less than 5,000 to 10,000.

Senator SPECTER. What are the other agencies, either governmental or voluntary, which service the street people?

Mr. SNYDER. There are approximately 20 shelters in this city, emergency shelters, overnight shelters for men and women. There is also family shelters.

There are a limited number of mental health agencies; there is a limited number of community centers where counseling, alcoholic rehabilitation, drug rehabilitation is available. There is a fairly broad spectrum outside of the Department of Human Services that, over the past 5 to 10 years, has grown in number and diversity that are attempting to meet the needs of those on the streets.

The only thing that all of them share in common is the recognition that resources are inadequate and that they are growing more inadequate because the problem is rising almost daily.

Senator SPECTER. How many of those shelters, if you know, are provided by Government as opposed to volunteer organizations? You say there are 20 shelters?

Mr. SNYDER. Actually there are 19; 10 shelters for men and 9 shelters for the women, with a total of 760 beds for men, 214 beds for women. The city operates two shelters, Blair and Pierce School. Each has the capacity of 150, a safe capacity of 150. They have recently, under a strenuous encouragement, opened another school called the Bundy School, which right now has 91 beds, but we intend to lend them 50 more today so that they can increase their capacity.

The rest of the shelters are all operated by private organizations or volunteer or religious groups.

Senator SPECTER. You say you have been in the field for some 11 years.

What has the problem been in terms of this evolution over this period of time?

Mr. SNYDER. The old poor have been with us a long time. The deinstitutionalized mental patients, very large numbers, alcoholics, folks who we had gotten very used to seeing generally in the lower income sections of town, the Bowery in New York, certain parts of Washington, skid row in Seattle. The places where we come to expect to find the folks. And they became invisible because we got so used to seeing them and they were so predictable that we overlooked the fact that they existed. And it must be said that those old poor, at one time 15 years ago, that the deinstitutionalized mental patients were not the old poor. They were folks who began to feed into an existing problem and have since swelled the ranks of the membership.

Senator SPECTER. Did the problem of the street people exist before the deinstitutionalization which occurred about 20 years ago?

Mr. SNYDER. Yes; we have always had a subculture in our society from the earliest, the earliest reported of 250 years ago. There were stated instances of people who were either retarded or mentally incapacitated or alcoholic or, for one reason or another, could not sustain themselves.

Senator SPECTER. A smaller number?

Mr. SNYDER. In susceptible ways. Well, in smaller numbers, plus we had a very different kind of country 200 or 100 years ago. We did not let somebody wander around our town eating out of garbage pails, sleeping on doorsteps. The community tended to care for that person and provide them with necessities that allow them to at least maintain a reasonable standard of living. That has changed, and during the last 30 or 40 years, what has developed, or 50 years, what has developed is a more institutional response that allowed the majority of the people in this country to ignore or overlook this problem and not share in solutions to that problem so that it becomes, through the Gospel Missions, through the Salvation Army, a problem that has dealt with in a more institutional and more invisible way.

Senator SPECTER. During the 11 years that you have been involved in this problem, have the numbers of street people grown materially?

Mr. SNYDER. The numbers have grown since last week. They are growing virtually daily. We are seeing more and more people as a result of the fiscal year 1983 budget kick-in. We see more people being evicted. We see more folks who, because of impossible choices, find themselves either on the streets or completely destitute, no resources, or not enough resources to survive a city like this.

Yes; the numbers are growing. They have been growing for most markedly, most noticeably for the last couple of years, although the numbers were large long before 1980 and long before it became either fashionable or so pronounced that people could no longer overlook the fact that we had a massive problem on our hands.

Senator SPECTER. To your knowledge, are the cases frequent where people die on the street? As the one that was written about this morning on Freddie?

Mr. SNYDER. To the best of our knowledge, and it is only to the best of our knowledge, because mortality figures in the city are now highly politicized, and we can no longer trust the statements or the information released by the medical examiner. We must know where someone has died, on what corner and what date before we confirm that.

To the best of our knowledge, six men in the District of Columbia, since December 12, have died, died there as a result of exposure or exposure-related causes. All of them were homeless, all of them were destitute, all of them died either because shelter was not available to them nor was it accessible to them. Freddie is a perfect case point.

We picked him up on Thursday night and brought him into the shelter that was opened on Thursday night, Bundy School. Freddie had a hard time walking. He was in pretty rough shape. They asked him to

leave, as they did everyone else, at 5:50 in the morning. The next night, when we went to pick up Freddie in Georgetown, he said no thanks because I cannot deal with coming out at 6 o'clock in the morning. It is too cold and it is too far to walk at that hour.

Senator SPECTER. Why did they ask him to leave at 5:50 in the morning?

Mr. SNYDER. Why?

Senator SPECTER. Why.

Mr. SNYDER. Because it is city practice. You must leave by 5:50 in the morning. I do not know whether it is the Protestant work ethic that says people should be released so that they can go out and find jobs, nonexistent jobs, nonexistent labor pools, or whether to make charity so distasteful and so unacceptable that many of the people who are on the streets would choose to risk death or serious illness or injury rather than to partake of the hospitality of the city government. But the city shelters, since they have been opened in the last 5 years, have traditionally asked people to leave between 5:30 and 6 o'clock in the morning which greatly discourages their use. It is not fun to be out at 5:00 in the morning, at 15 to 20 degrees outside, with absolutely nowhere to go. Freddie is a perfect example of one who chose to die rather than put himself in that sort of position. Because at least he could stay in a phone booth until 7 or 8 o'clock, stay there and die. Those are the kinds of options that many people in this city are faced with.

Senator SPECTER. Do you agree with the opinions on deinstitutionalization which have led to some of this problem when those decisions first arose some 20 years ago?

Mr. SNYDER. Yes, of course. I have been in institutions. I have been in prisons. I have seen what it is like when human beings are warehoused. It is not pleasant, it is not dignified, and it is not civilized. So the idea that people who are not a clear and present danger to themselves or other people should not be institutionalized all of their lives. That makes absolute sense. The only problem is that for all those folks for whom that made absolute sense never dreamed that we live in a world where we would send those people from those institutions to the streets to eat out of garbage pails, to sleep on park benches, to sit day after day in corners talking to themselves, surviving as best they can. It did not occur that we would not create the community kind of based facilities that would allow those people to live with some degree of dignity and to begin to regain some of the productivity that they have lost because they lived in a society that made it difficult for the mentally handicapped to participate.

Senator SPECTER. Mr. Snyder, in your last answer, you referred to the fact that you yourself were—how did you characterize it, in a prison?

Mr. SNYDER. That is right.

Senator SPECTER. Would you mind sharing that experience with us in terms of what you are commenting about, warehousing, et cetera?

Mr. SNYDER. I would be more than happy to share if anyone wants to go back to jail with me, too. From time to time, I find myself in and out of those places. I spent a couple of years in prison back in 1970.

Actually, I was a management consultant back in the good old days on Madison Avenue, and woke up one morning with a cold sweat and realized that it was a silly and frivolous way to live.

Senator SPECTER. How long were you a management consultant on Madison Avenue?

Mr. SNYDER. Oh, I managed to swallow it for a couple of years, long enough to realize that I had a bright future. I was aggressive.

Senator SPECTER. What is your educational background? What schooling did you have before you became a management consultant?

Mr. SNYDER. I have 1 year of high school. I liked education so much that I could not stand public schools. I dropped out of school early and spent a lot of time reading, studying on my own. I tended to educate myself more.

Senator SPECTER. What kind of work did you do as a management consultant?

Mr. SNYDER. I used to advise large corporations on how to run their businesses, how better to maximize their use.

Senator SPECTER. Were you successful at it?

Mr. SNYDER. Oh, yes, I was very good.

Senator SPECTER. Why did you leave it then?

Mr. SNYDER. Because it was a silly way to live.

Senator SPECTER. Why?

Mr. SNYDER. Because it is dedicating your life to the pursuit of either personal wealth, personal security, helping people how to figure out better ways to sell Twinkies or instruments that—technological sophistication, that are relatively meaningless, and useless and in a world where millions of people are starving. And at one point—at some point, it made no sense to me and I realized that I had to move away from that way of living, and I had to move into another way of living.

Senator SPECTER. And what did you do after you left being a management consultant?

Mr. SNYDER. I traveled around the country for about 6 months. I fortunately or unfortunately, I would say fortunate enough to find myself in Nevada visiting some friends where I then caught a ride to California with someone who had illegally rented a car, and I was the unfortunate passenger that got 3 years, and spent 2½ of those years in prison. And I am deeply grateful for that experience.

Senator SPECTER. What prison?

Mr. SNYDER. Oh, lots of prisons. I was not a model prisoner. I was in Danbury, I was in Lewisburg, I was in Springfield, I was in Lompoc. I spent a lot of time resisting what I felt was a very unfair and a very silly way of keeping humans caged like animals; fasting, organizing, and sharing in work stoppages; so I managed to make the tour of the Federal system. Quite educational.

Senator SPECTER. Did they move you from one to another because you were pursuing these activities?

Mr. SNYDER. Yes; the one thing you discover very quickly in prison is that the community is not permitted—those who administer the prison prefer not to see people come together and work together and grow

close because they see that as a threat. In some sense, they are right. There is a threat to the existing order.

So whenever prison officials would see groups of people coming together and growing closer and sharing lots of time and discussion and activity, they would tend to break them up and send one here and one there until the same thing would develop, and at the next prison, you would find yourself moving somewhere else.

Senator SPECTER. Mr. Snyder, what do you think is the answer to the problem of street people?

Mr. SNYDER. That, of course, is a very difficult question, as you understand, otherwise we would not be having these hearings.

First is that we have to at some point, we have to stop talking about shelters and soup kitchens. Housing is what there must be. And unless human beings are allowed to live with some degree of stability in environments that are economically and morally and ethnically responsible, then there will be large and growing numbers of people who—

Senator SPECTER. Well, what kind of housing are you talking about? You are not talking about institutionalized housing?

Mr. SNYDER. No; there are some examples around for those who are willing to look. In New York City there is an experiment that is called the St. Francis Hotel that was organized by the Franciscans, the Catholic Church. There you have a group of people, and they have not simply skimmed the best, they have not gone to the cream of the crop and the easy ones to deal with. They had many people who many folks would consider impossible to work with. What they have done is create a housing complex where folks who otherwise would be either institutionalized or on the street are able to live with their own private, although small, housing. They have facilities available that provide counseling and support services, good food. They do it all with a portion of the money which the Franciscans have arranged to see that they receive. Many of them—all of them were entitled to benefits. Many of them receive no benefits because they simply cannot work their way through the bureaucratic maze. And so with a percentage of the resources that are legitimately available to those people, they have been able to create longer term housing that has within it the kinds of support mechanisms and the kind of nutrition and the kind of programs that made it possible for people to do more than simply spend 8 hours in a lice-infected building to return to the streets and to live the life of the homeless. That is fiscally very responsible; it is a lot cheaper than creating shelter space. They discovered in New York it is 15 to—

Senator SPECTER. How expensive is that?

Mr. SNYDER. The exact figures are not here before me. It is 10 to 15 times more expensive to create a shelter bed and maintain it than it is to create long-term healthy and dignified housing. So there are no economic reasons why we do not do that.

One of the reasons that it is not being done is because we have not reached the point where we are prepared to provide the kind of emergency space that will allow our most helpless citizens to live through the winter. So what seems to be lacking is an understanding, in a sense

of proportion and urgency, that first allows us to open up the spaces to bring the people inside in an emergency basis and then prompt us to develop longer range and longer term housing.

Senator SPECTER. What do we need on an emergency basis, as you characterized it?

Mr. SNYDER. Well, there are a number of possibilities that are open to us. We, over the last 4 or 5 weeks, have suggested to Members of Congress, both through the mail and in personal meetings, that what Congress can do and should do as a way of contributing to at least a temporary solution and an immediate response to what is obviously a growing problem is to order the availability of the Federal buildings throughout the country to State and local governments and community groups that will and can utilize those spaces as emergency overnight shelters, particularly during the winter months, when thousands of people may die, may die of exposure, hypothermia, and the lack of shelter.

Senator SPECTER. What kind of Federal buildings do you have in mind?

Mr. SNYDER. We have lots of them here. I spent 4 months on a heat grate in 1980 at 19th and C Street, sitting opposite the Interior Department, where a lobby large enough to hold 1,000, 2,000 people remained lighted, heated, guarded every night, while hundreds of people walked back and forth in the middle of snowstorms with no place to go.

Senator SPECTER. You thought of moving some beds into the lobby of a building like the Interior Department?

Mr. SNYDER. We tend to be very, very humble in our demands and expectations. We would say keep the beds, open the space, give the people a blanket and let them lay down and curl up on a floor, and at least we will not have to pick them out of telephone booths to take them to the morgue to identify their bodies because they have frozen to death. That at a minimum can be done. That also can help to make it a bit more clear the nature of the magnitude of the problem. There is still a tremendous amount of ignorance. There are stereotypes which all of us cling to tenaciously, partly because our own psyche needs that, we do not like to pass human beings on the streets at night, step over their broken bodies and believe that they are in fact like us, human beings; that they could and should get in off those streets. We prefer to see them as the dirty lazy drunken bums, both for whom there are no answers and there are no solutions. It makes it easier for us to sleep at night and it makes it easier for us to go about our business.

I notice those people begin to come inside when we can begin to see that they are in fact just like us, but for the grace of God, we may wind up there, then the longer term solutions—then the solutions become much more clear and much more possible.

Senator SPECTER. How are you funded, Mr. Snyder?

Mr. SNYDER. Small donations. We would not accept Government money if it came in a brown paper bag in the middle of the night. We do not pursue or attempt foundation money. We are not interested in anything that requires development of bureaucracies as the price of its acceptance. We receive only small donations. We receive primarily in

terms of goods those things which other people have determined to be unusable, discardable. We spend about \$3,000 or \$4,000 a month to do what it would cost the Government millions of dollars a month to do, from the running of the shelters which we are paying for—by the way, it is going to cost us \$1,700 a week for the privilege of volunteering our nights in a shelter for men, women, and children in the Southeast because we understand that the Education Department cannot use education money for that purpose. And so we have taken on the responsibility of involving churches and community groups in a sharing of their expense; we have developed and are developing a network of volunteers that will provide the staff; we have called on the Washington Board of Trade to get together with its members and provide some food. Your staff, particularly Elizabeth Montgomery, has been incredibly helpful in both securing that building and arranging for beds. The city has been trying for 6 days to find beds. They only have 91 beds in the Bundy School, and they have been turning away 50 to 60 people a night to the other city shelters. They were not able to find beds. Ms. Montgomery was able to encourage the National Guard to lend us 500 cots for the winter. That kind of activity is, of course, obviously possible. There are groups within this country who would like nothing better than to have a little bit of space where they could put in a few cots and put in a few blankets and just provide the basics and allow the people to come in off the streets. All they are waiting for is that space and all a lot of other people are waiting for is to roll up their sleeves and go to work if the opportunity—the invitation, the understanding that there is a need and that they are in fact needed.

Senator SPECTER. Would you have an estimate as to what was the total of contributions given to your organization in cash and value, foodstuffs or other items, for last year?

Mr. SNYDER. Probably about \$40,000 to \$45,000 in cash. It is impossible for us to measure the value of foodstuffs.

For Christmas, a local restaurant called up and gave us 500 pounds of prime ribs. I understand that most people could not afford to buy any, that it is too expensive and too good. We were able to have a Christmas Eve party for about seven or eight homeless people. We get all kinds of food, clothing, resources that we distribute from charity folks, and I would not begin to estimate the cost except it is in the thousands of dollars a day.

Senator SPECTER. Beyond the issue of opening up space, which you suggested like in the lobbies of the Department of the Interior, for example, what other immediate response could the Government give to this problem?

Mr. SNYDER. Food. I mean one thing we have learned, we first started by opening a soup kitchen. That was our first effort in reaching out to our neighbors which led to the development of hospitality houses, medical centers. I mean it is obviously a whole—

Senator SPECTER. Is the Federal surplus food made available to you at all?

Mr. SNYDER. No; we are not eligible. We are not tax exempt. Despite the fact that we feed more people than everyone in the city of Washington combined.

Senator SPECTER. Are you taxed?

Mr. SNYDER. Are we taxed? No; we would not pay taxes.

Senator SPECTER. But you are not tax exempt?

Mr. SNYDER. No; we pay no taxes, not because we are not tax exempt, but because we choose not to contribute in what we believe a waste and misuse of financial resources.

Senator SPECTER. You are not saying because you are not tax exempt, you are not qualified for Federal surplus foods?

Mr. SNYDER. That is right. But there are many groups that are, and there is, as I am sure you know, credible quantities of food, there is enough milk to supply this country for 3 years, butter, cheese, all high protein, grains. There are folks in this country by the thousands who are malnourished, thousands and thousands of children are going to bed hungry at night. That is unnecessary when we are sitting on enough food to feed them. In the near future and for the near future we can alleviate that problem.

Senator SPECTER. Beyond the suggestions you have made as to what the Government should be doing, what suggestions would you have for additional contributions from the private sector?

Mr. SNYDER. Well, for one thing, I should be very clear that we do not want governments to do very much because our experience is when Government does very much, it does a very bad job of it. So what we see, at least in terms of the provision of the immediate emergency shelter, has been the best contribution and the only contribution the Government should make is buildings, nothing more. We see the religious community as having an absolute and greater responsibility than the Government to provide the human resources that can create the atmosphere which will bring the folks, particularly those over the years that have been so broken and so brutalized that you simply cannot pull up with a camera and say come on to a shelter. You have to be able to offer a lot of concern and a lot of care. The religious community can do that. The private sector can contribute the resources, the beds, the cots, the blankets, the food, those things which it has and which it can make available.

And as far as we are concerned, no human being should live in a society free of the responsibility of citizenship, which means that there are millions of human beings in this country who are homeless and destitute, which there are in each of us, particularly each of us who has a home, some resources available, has an absolute responsibility to do something about it. Whether that means volunteering at a soup kitchen, cleaning our closets or our food pantries, making available these things that we do not need, which other people do, our time, our energy, our skills, each of us has a way in which we can and should contribute.

Senator SPECTER. If I were to make suggestions to the private sector as to what they might do on this problem, whom would you suggest that I call upon and what would you suggest that I ask them to do?

Mr. SNYDER. I would suggest that you ask them to do nothing until Congress does something. Our experience is that you can only get someone to do something if you ask in a position of both authority and legitimacy. Right now the Congress has done virtually nothing that we know of to alleviate the problem of need. So the first thing that I would do would very quickly, with a sense of proportion and sense of urgency, do something, whether it is making available public buildings, some kind of emergency funding, a couple of bills floating around, do that, and out of that posture, say Congress has done something, it may not be a lot and it may not be everything that should be done. We are trying to do something, now here is what you can do.

Senator SPECTER. All right.

Assuming we can get a couple of buildings available, a couple of lobbies available, then whom would you suggest that we ask to do what?

Mr. SNYDER. Then I would call on the Board of Trade and ask them to put some beds or cots in there or mattresses. I would ask them to come up with some food. I would ask them to provide some of the services that would make it possible to not just maintain bare overnight shelters but it would make it a little more fooling around with these services. And then I would call on the people of the city and say come, come and do some work. Come and volunteer some of your time because we are going to do it and we invite you to do it with us.

Senator SPECTER. Mr. Snyder, thank you. Thank you very much.

Mr. SNYDER. Thank you.

Senator SPECTER. Thank you for coming.

Mr. SNYDER. I appreciate it.

Senator SPECTER. And thank you for giving us some thought.

[CLERK'S NOTE.—Subsequent to the hearing Mr. Snyder supplied the following information.]

Mental Health, Mental Hospitals, and the Homeless

Mental hospitals are the POW camps of our undeclared and inarticulated civil wars.

Dr. Thomas S. Szasz
The Second Sin

If mental hospitals are the POW camps, then ghettos and slums are the battlegrounds. Every emotional breakdown is an inarticulated protest against a complexity of social, communal, and familial conditions and relationships that stifle and threaten the individual's psychic viability. A psychotic episode is a socio-political event and not a medical event.

Anthony E. Colletti
"Psychiatric Oppression and Class"

Since 1965, the population of mental hospitals has declined by 75 percent, as the result of new philosophies and practices in the mental health field. One of the major vehicles forecast to support this exodus has been the community rehabilitation residence (CRR), in theory a facility to provide support in easing the transition from the state hospital back into the community. Unfortunately, no city in the United States has enough CRR slots to accommodate the number of ex-patients in need. In fact, most cities have only a token number of such facilities.

By the hundreds of thousands, patients have been discharged and sent to unfit, unsafe, or unlawfully operated boarding homes and flop houses, without the necessary supportive medical or social aftercare services. Others are given bus fare and the address of a mental health center, and then discharged with neither planning nor preparation.

Since depopulation of America's mental asylums began, the majority of the state mental hospital

Next to a widely circulated belief that our streets are populated by alcoholics, the other well-established image of the homeless is one of "crazies," muttering, pattering souls, laden with baggage, orating at street lights, or shouting at invisible beings. Their appearance tells us that they do not even care for themselves. Their persistent presence in public places tells us, among other things, that they reject our efforts to help and *choose* to remain in miserable circumstances.

It is, in fact, true that many of the homeless are discharged mental patients. The Pine Street Inn is Boston's oldest and largest emergency shelter for men and women. Executive Director Paul Sullivan estimates that more than 50 percent of Boston's street population are ex-mental patients. According to an internal memo written by the New York State Office of Mental Health, in New York City, where there are an estimated 36,000 homeless men and women, 50 percent display signs of mental illness, and one-third have had psychiatric hospitalization. The now-defunct Washington, D.C. Mayor's Advisory Commission on Homelessness conducted an investigation of mental health problems among shelter users. They discovered that more than 50 percent of the men and 70 percent of the women have had contact with the mental health system. Information provided by hundreds of organizations over the past few years leads us to the conclusion that between one-third and one-half of the homeless people in America are ex-mental patients. A bare knowledge of recent history and a look at some of the studies of urban homelessness confirm this.¹ (It now appears that Reaganomics will alter the makeup of America's street population in the next 10 years, in much the same way as deinstitutionalization did over the last 10.) But if there are now many discharged patients, they were once confined, and not all for the same reason.

Emptying the Hospitals

Publicly supported mental institutions were first constructed in the United States in the early 19th

century. By 1955, the population in almost 300 state hospitals reached a peak of about 559,000 patients. Nearly half of America's hospital beds were occupied by mental patients. The state hospitals suffered from a lack of funds and staff, and conditions were shameful.

By 1980, slightly more than 137,000 patients were hospitalized for mental illness. Several explanations can be found for the decrease, which resulted in more than 75 percent of the patients leaving the hospitals at the same time that the general population was growing.

First, the prevailing philosophy—that those needing mental health care should be treated in hospitals—shifted to a new ideal that community-based care was the answer. The development of new psychotropic drugs meant that more patients could be maintained outside a hospital setting. The rights of mental patients were increasingly expanded and upheld by legal, legislative, and judicial measures. The federal government assumed more and more financial responsibility for chronic patients being discharged to nursing and board-and-care homes, with Supplemental Security Income (SSI), Medicaid, and Medicare providing necessary funds.

How many chronic patients are there? According to one estimate, "There are 1,100,000 schizophrenics [in America], 180,000 of whom are in hospitals and almost a million in the community." Combined with estimates of elderly and severely mentally disabled patients, the total is between 2 and 4 million.²

The alternative of care and support from community facilities was enunciated in 1961 by the Joint Commission on Mental Health, created by the Mental Health Study Act of 1955. While the commission acknowledged that "the objective of modern treatment of persons with major mental illness is to enable the patient to maintain himself in the community in a normal manner," it also pointed out that "aftercare and rehabilitation are essential parts of all services to mental patients. . . ."

Community treatment was a concept welcomed in many sectors, but it was debilitating to have supporters with both fiscal and humane motivations. While many assumed that community-based facilities and support services would develop commensurate

with need, they did not. The establishment of a comprehensive community care system would have undermined the principal incentive of financial savings, since the low cost of community care is tied to the meager services offered. If appropriate support services, shelter, and medical care were extended to former patients, community costs would rise substantially.

Nationally, 1,000 mental patients per day are discharged from institutions. Only 7 percent of those are referred to operating community mental health centers. Not all of those make it to their appointments, and those that do may not find the help they need.

The community mental health centers are presently providing services to the neurotic, borderline patients with a good prognosis: the so-called YAVIS (young, attractive, verbal, intelligent, and successful) syndrome. Treatment of the ex-hospital patient is of little interest to the psycho-therapeutically oriented staff at the mental health centers. Any treatment afforded the chronically mentally ill is the most expedient one, namely, psychoactive drugs.³

There are differing views of the costs involved with community and institutional care; different studies report different conclusions. In some cases, community costs may appear to be lower because some necessary non-psychiatric costs (food, shelter, clothing) are not provided by publicly-supported community care facilities, but instead are covered by Medicaid and SSI, as well as by family members and private groups. (Further, these costs disappear for the homeless ex-patient.) Direct treatment costs may, however, appear to some to be higher in the community, and other burdens may be added, such as

an increased reliance on law enforcement agencies or support for families.

But the fiscal savings theoretically available from deinstitutionalization are far less than had been originally calculated. Many of the costs of a mental hospital are fixed, regardless of the number of patients occupying the institution. As the population goes down, the per person per diem cost goes up. Much of the savings potentially available will not be realized unless and until the institutions are closed altogether and the fixed costs eliminated.

In actuality, a goal of humane and cost-cutting deinstitutionalization of patients became instead the dubious achievement of careless and widespread emptying of wards full of patients. The community facilities and support provided to them covered a wide range. Some were "papered out" to spurious living situations with relatives who had no intention of keeping them. Some got a bus token and directions to a mental health center. Some moved to private profit-making homes in the community. Some went directly to the street and remained there.

It is not unusual to find a conflict of bureaucratic processes which sequentially 1) dictate a patient's release, 2) begin the qualifying process for benefits just prior to release with the expectation that weeks or months will elapse before the first check is issued, and 3) eventually, see the individual fail to receive benefits because of having no fixed address.

According to a National Institute of Mental Health report, "National statistics show that 38 percent of the discharged mentally ill were not referred to any aftercare services and another 11 percent were transferred to nursing homes and other state hospitals." Other findings of follow-up care report conclusions consistent with the reality of street life; patients (more than one-third in one study) preferred hospital life to the emotional isolation and loneliness they found in the community. Further, one study of discharges showed that, in the early years of depopulation, about two-thirds of the former patients went back to their families and not more than one-fourth went to nursing or boarding homes. With the passage of time, however, the more "difficult" and more severely/chronically ill patients remained and

the distribution of discharges changed radically: in 1980, only 23 percent of the patients were returning to their own homes.⁴

It must be remembered that these figures reflect "official" outcomes of discharges, as opposed to the obvious reality that many patients simply end up on the streets with no alternatives and no assistance. Follow-up reports on patients outside the hospitals are usually narrow in two respects: they interview patients who have managed to avoid return to the hospital, and they do not locate patients living on the streets, whether those patients went directly from hospital to street or walked away from another situation, such as a board-and-care home.

All of this begins to reveal some of the dimensions of deinstitutionalization and public hospitals. Certainly more has been said eloquently and authentically by those who emerged from institutionalization and "treatment" with enough literacy to pass on their observations and experiences. But the overall invisibility of the homeless places them out of this category for all but the few who strive to form ties with them. The call here is always to examine the burden (rarely the favor) conferred on those most physically weak, psychologically incapacitated, or politically powerless. In this light, the wholesale depopulation of mental institutions during the last decades emerges with a record of neglect and criminal unconcern, resulting in a massive increase in the number of homeless people on our cities' streets.

Why Were They Hospitalized? - The Hospital as Tool

There is a common cause for why, before the age of "enlightenment," these people were separated and segregated, locked up in hospitals for days or years, shocked, drugged, and otherwise "treated." Each of them - in a large or small way - violated the ritual ceremonies that make up society's "norms," as agreed upon by those who prevail (economically, politically, socially, and otherwise). Observed by others, they marched to a different tune. Hospitalization and

various forms of treatment followed. (We respond to observable, unacceptable differences as if "normalcy" is a static, immutable reality, not at all fluid or subject to modification, change, or varying interpretations.)

Several obvious questions are thus raised. One concerns how anyone - rich or poor, black or white, female or male - comes to be hospitalized for a state not acceptable to the rest of us, but does not necessarily threaten the health or well-being of anyone. In answering that question, we must consider the justice of the admission process, for if the wards were filled through oppressive measures, what light does this shed on a release process that has been careless and wholesale by many accounts? The second question bears on the "deinstitutionalization" movement of the last two decades and its impact on the number of homeless people in this country.

Any detailed discussion of these topics must do more than repeat the plethora of analysis that has gone on before. It must also take into account more deeply-rooted truths about poverty and justice in our society. Such an examination can be done only briefly here. First, what are the origins of the dividing lines of acceptability and unacceptability?

... From childhood onward, stories make the invisible forces of life visible by creating images of people representing ideas and social types, and assigning some fate to each. ... [Advertisements] present styles of life telling us what values we should choose and at what price. ...

If deviants didn't exist, they would have to be invented in order to generate a sense of what the norms are and what the price for violations might be. ... [Deviant images] have developed to deal with the large majority who need to be socialized into roles of conformity and acquiescence and dependence upon stronger and more authoritative types.

In order to perform these functions, images of deviants have certain characteristics. These images tended to develop in predictable ways to depict menacing forces against whom people need to be protected by strong and frequent resort to violence. . . . The first of these is unpredictability. . . . As rationality of a relationship, the aspect of unpredictability justifies irrationality of behavior toward the mentally ill. . . .

The second critical aspect of the image is danger... constantly reinforced by the label "ex-mental patient" being attached almost exclusively to violent and bizarre behavior. . . .

Next, the image of mental illness has to be tinged with a touch of evil. Sin or moral flaws tend to justify the potential irrationality and brutality of the relationship toward the persons depicted, suggesting that they asked for or deserved it.⁵

When people then behave outside the prevailing norms, when they violate the ceremonies, they have the possibility of being classified and treated as criminals, prophets, geniuses, or mentally ill, the last being the case at hand.

. . . Society is particularly concerned about people who do not properly engage ceremony. One must not violate communication ceremony by focusing somewhere other than the listener's face! One must not violate ceremony by speaking audibly to an unseen listener! One must not violate ceremony regarding tests of truth by averring that one speaks directly to a Truth-giving God! . . .⁶

The establishment of "sanity" for a given person is a value-laden undertaking. It needs a moral framework as well, and that should be broadly defined as questioning whether life itself is affirmed or not. Considering the extent to which personally and collectively destructive behavior is legalized and accepted - e.g., cigarette smoking, driving cars, drinking alcoholic beverages, abusing the public trust, building and threatening the use of nuclear weapons - the standards for deviance, sanity, and criminality are clearly in the eye - or the conscience - of the beholder. A man conversing with a park bench seems infinitely easier to come to terms with than a megaton-mad warrior in public office.

An exclusive group of the "haves" (of knowledge, property, and weapons) consume creative energy and national resources that could take the patient from hospital to community, rather than to street or shelter. Yet it is the poor, minorities, and women - all casualties of disenfranchisement by the norm-setters - who are locked up. They are labelled, and, in many instances, turned onto the streets without shelter or resources, and without the capacity to manage a bus ride, tie their shoes, or report for medication.

Race, Class, Gender, and Society

The roots of psychiatric oppression by race, economic class, and gender are, not surprisingly, well-disguised, for history and psychiatric theory are authored from the same group that issues norms: the dominant class. But the trend has not gone unobserved, particularly by patients themselves, as in the following:

... Upper middle class women enjoy the boutiqueing of psychiatry and engage in private therapy; they are labelled neurotic, and it is considered in vogue. Lower class women are commonly diagnosed as schizophrenic, incarcerated in state hospitals, administered electroconvulsive treatment (shock therapy) and tranquilized into a stupor. Schizophrenia

is not in vogue . . . 80 percent of those in state hospitals are so diagnosed. . . . Most of what has been labelled schizophrenia among the poor is dysfunction resulting from the trauma of environmental stress factors. . . . A welfare mother, overwhelmed by environmental and economic stress, falls into a depressed stupor-involitional melancholia or urban stress fatigue? Is she mentally ill or a social casualty?

. . . There is a disproportionate rate of dysfunctionality among the lower classes, and this is a direct consequence of the stress they live under. They are not mentally ill; the cure is neither a state hospital, nor shock therapy, nor tranquilizers, but social change. . . .⁷

Some say this is confirmed as a truth by the reality that, among young blacks' (the group aged 15 to 19 whose unemployment rate is the nation's highest, at over 50 percent), the leading cause of death is suicide. Dr. Jay Chunn, Dean of the Howard University School of Social Work, cites chronic unemployment and loss of personal relationships as primary factors leading to what he calls "an epidemic" of suicides.⁸

Ten years ago, some 19 percent of mental hospital admissions were "nonwhite." By 1975, this figure had risen to 23 percent. Per 100,000 people, the admission rate for whites is half that for blacks.

Blacks make up 19 percent of patients in public general hospital psychiatric wards, but comprise only 10 percent of private general hospital psychiatric ward patients. In private psychiatric hospitals blacks constitute a mere 3 percent of patients. (Citation omitted.)

Even more shocking is the source of state hospital admissions for national minorities, who are increasingly being sentenced to mental hospitals by courts for incompetency to stand trial.

The percentage of nonwhites thus admitted is 6.9 percent, 5.5 times the percentage of whites, and the number of Spanish-Americans is 2.5 times the white percentage. Translated into absolute numbers, 5,369 blacks were admitted in 1972 for incompetency to stand trial. That amounts to nearly 1.5 times the absolute number of whites, even though blacks constitute only one-fifth of the state hospital population. This raises the possibility that the custodial state asylums [are] being maintained for an increasingly third world population, and coordinated with a racist judicial system.¹⁰

Narrowing Choices for Care: Closings and Cutbacks

One way of measuring the success or failure of discharge programs is to examine the scale of readmissions. This factor quite adequately makes the point that many former patients have failed to survive in the community, if the conditions of release ever truly gave them a chance. Most chronic mental patients do not stay in one place too long: insurance coverage usually affords no more than a few weeks in community hospitals, and the state institutions are quick to discharge them because their illness is unresponsive to treatment. According to a California study of a Veterans Administration Hospital, 79 percent of the applicants in a 3-week period were "revolving door" patients, more likely to be homeless and schizophrenic.¹¹ An equally succinct and illuminating statistic is this one: 50 percent of all discharged patients in New York State return to the hospital within 4 years.¹² Finally, it has been shown that readmission figures skyrocketed in the years

following deinstitutionalization, and that the long-term effects on patients in the community are grim: few keep jobs, the majority live in total or moderate isolation, and few remain in aftercare for more than a year or two.¹³

If readmissions signify a failure to survive in the world at large, we must ask how much more difficult this survival is for the poor patient and for the patient who has no support on leaving the hospital? Is there any way to know what portion of the readmission rate reflects the will to survive (i.e., procure warmth, food, a bed) and which part reflects a failure of previous "treatment"? Or must we not ask if the "treatment" of a person in mental anguish does not include the guarantee of these basics?

A 1979 Maryland State Department of Health and Mental Hygiene study estimated that 28 percent of returning patients thought their most pressing problem was acquiring and maintaining adequate shelter. In Richmond, Virginia, where public shelter resources are grossly inadequate, even the option of returning to the hospital is no longer available, for, in April 1982, the Richmond Metropolitan Hospital closed its public psychiatric unit, leaving poor patients with nowhere to go. Community hospitals are unable to provide for them, and the move drastically cut services to those already deinstitutionalized - about 50 percent of those seen by the city's half dozen mental health clinics.

Another facility sometimes available, the Medical College of Virginia, was seeing a 10 to 15 percent increase in mental care cases in its emergency room *before* the closing. Poor patients generally occupy about one-fourth of MCV's psychiatric beds.

While money was the overriding factor in the closing, it is not a consideration when confining poor people who are under a court detention order for care, because these costs are paid by part of the criminal justice system - the Virginia Supreme Court. But at least one mental health center administrator has said publicly that workers are under pressure to "keep people out of the hospitals," and from April to July 1982, with city funds available to hospitalize only 10 people for less than a week, *no* acutely ill uninsured

mental care cases with previous hospital histories were able to use city funds for treatment

Costs are the oft-cited factor for many closings or threatened closings in recent years. The long-term community effect for poor people looks to be disastrous. No-frills public services are the only option for many people, and even when these programs are uninviting or saddled with a 9-to-5 effort, they are all that is available to the poor.

A case in point is the threatened shut-down of federally-funded St. Elizabeths Hospital in Washington, D.C., the city's only public facility for mental care cases. In December 1981, Office of Management and Budget Director David Stockman outlined plans to close the hospital or severely cut its funding. As described by Dr. Barbara Tobelman, Executive Director of the Mental Health Association of the District of Columbia, community reaction ranged "from disbelief to outrage."¹⁴ A local union official cautioned that "the nation's capital must not become a psychiatric ghetto."¹⁵

Virtually all witnesses at a D.C. Mental Health Association hearing on Stockman's plan addressed the impact of closing the sole public psychiatric facility in a city of black and poor people who do not even have a vote in Congress and, until recently, did not have the chance to elect their own officials

Dr. Ruth E. G. King, of the D.C. arm of the Association of Black Psychologists, cited several major consequences of closing St. Elizabeths, given that there are not a sufficient number of private beds available to absorb remaining patients:

- * *drain on existing D.C. mental health and social service facilities;*
- * *displacement;*
- * *devastation of family systems;*
- * *higher death rates for former patients;*

** increased crime from severe economic pressures; and*

** devastation of neighborhoods.*

"So, in essence, we are looking . . . at the impact of releasing mentally ill patients back into the predominantly black neighborhoods of Washington, D.C. . . ." said Dr. King.

Pointing out that some patients will inevitably end up in D.C. Jail from the hospital, King added: "... Where will the patients go? Where will the patients receive needed services? Is Ronald Reagan going to take them in at the White House? Is Stockman or OMB going to allow use of their office building for housing?"¹⁶

Another witness echoed these views:

When the public was first informed of this proposal by way of the public media, many of us thought it could not be true - this was another trial balloon; another effort to formulate social policy through press release. Upon reflection, we must accept the fact that it is probably very true and likely to happen in the near future. After all this is the Administration which was willing to accept the designation of ketchup as a vegetable; willing to give states additional control over monies and programs while cutting the states' amount of federal revenues for these same programs; willing to cut social security benefits for the population most in need of that income and very recently, the Administration which is willing to use tax dollars to fund segregated education.¹⁷

St. Elizabeths offers a unique example of the workings of deinstitutionalization, if only because it exists under the federal government. As such, it could be setting benchmarks as a model, implementing the findings and endorsements of previous federal mental health bodies. But, in fact, following the lawsuit brought by the Mental Health Law Project, the hospital has not moved very fast to carry out its court-ordered schedule.

As did similar lawsuits in other parts of the country, D.C.'s *Dixon v. Califano* mandated that specific increments of the hospital population be moved to community care facilities over a stated period of time. Not only have the hospital and the local government failed to do this, but some community agencies have cited cases where they have been paid to provide support services and training for a fixed number of former patients, and then have been sent none. While the D.C. government provided the court with a list of organizations and agencies which supposedly provide services to ex-mental patients, on closer inspection many have been found to be out of existence or not especially targeted for former patients.

It costs \$20,000 to \$25,000 annually to keep a patient at St. Elizabeths, while community placements (in home and group settings) run \$2,600 to \$3,200. This latter sum comes almost entirely from SSI checks, delivered directly to group homes. The larger amount is paid out when homes have the capacity for more than 50 beds; thus, operators are discouraged from creating small-scale homes.¹⁸

In the shift away from institutions, there has also been a series of studies of what are called "forfeited" patients: discharged and in need of services, they are least able to secure them, and eventually those charged with their care concede defeat in the struggle. No solid statistical information on how many of them wind up on our streets and in our back alleys has come out of these studies.

Many of these "forfeited" patients are among the 600,000 Americans in need of psychiatric care who are imprisoned for some period of time each year. For instance, in Los Angeles County alone, there was a 100 percent increase in the number of judicial incompetency dispositions following the passage of Califor-

nia's state legislation for mental patients. San Francisco police find they log more than 800 calls monthly on mentally ill citizens.¹⁹ A study of 500 arrested persons in need of psychiatric care found that all had hospitalization records, but 94 percent were not involved in any outpatient program.²⁰

Conclusions

Where does all this lead? There are clearly obstacles to the effective delivery of services to those in need. Given the number of chronic patients among the homeless, how can their needs be assessed, and what are the obstacles to meeting them?

A basic inventory of services would have to include:

- * available and accessible psychiatric aid;*
- * round-the-clock crisis intervention and support services;*
- * programs that instill skills for daily living;*
- * graded housing services for a range of needs; and*
- * financial support, employment assistance, and vocational rehabilitation.*

The obstacles to humane and effective delivery of such services are deep-seated, but not impossible to overcome. They cover the range of problems centered in the institutions and professions themselves - attitudinal, legal, administrative, ethical, and educational - to those that are the burden of non-patients. All of these problems, which have been well covered in other literature, require time and commitment to resolve.

There is also a need for a coherent public policy, with responsibilities clearly assigned at all levels of government and for all sectors of society. Such a policy would include:

- 1) *a plan of graded and wide-ranging opportunities and services, relying on increased public sensitivity and financial commitment;*
- 2) *full civil rights for those in need of mental health care:*

- * a bar on discrimination that is aimed at chronic patients, in the areas of housing and employment; including a ban on zoning discrimination;*

- * an affirmation and implementation of the right of both voluntary and involuntary patients to have adequate treatment in the least restrictive setting;*

COMMUNITY OF HOPE

STATEMENT OF REV. THOMAS G. NEES, PH. D., DIRECTOR

Senator SPECTER. Our next witness is Rev. Thomas Nees, who is the founder and pastor of the Community of Hope Church, the Nazarene, Washington, D.C. Reverend Nees' church helps homeless families as well as individuals. Reverend Nees has served on the President's Task Force on Private Sector Initiatives and the District of Columbia Commission on the Homeless.

Welcome, Reverend Nees. We appreciate your joining us and look forward to your testimony.

Reverend NEES. Thank you, Senator. I will read a brief statement and then follow with whatever comment you deem appropriate.

Homelessness has become an all too obvious problem in Washington, D.C. By day and night the city is inhabited by urban nomads, men, and an increasing number of women, who scavage for food and seek the most convenient shelter available. Publicly and privately funded facilities are constantly overcrowded, understaffed, and generally ill-equipped to care for those unable to provide their own shelter.

However difficult these so-called street people are to identify and count, they remain rather visible and the solutions to their problems are somewhat obvious. The majority of them are traumatized people, likely to be dependent whatever the economic conditions of the city. Once and for all we need a concerted effort to identify those living on our streets and do whatever is necessary to assure the facilities necessary to provide the critical minimums of food and shelter.

There is another dimension of homelessness, less obvious, and, in my opinion, more difficult to solve. This is the problem of homeless families in the city. For the most part family homelessness is not the result of psychological or addictive problems but simply the failure of our economic systems to provide the opportunity for every family to have decent, affordable housing.

Homeless families are seldom seen walking the streets together. You are unlikely to see a mother and children sleeping on a grate or eating in a soup kitchen. Some of these families can be seen in the emergency shelters provided by the city at the Parkside Hotel, the Pitts Motel, and the Capital City Motor Inn. In these places households are crowded together, several people in a single room for weeks at a time. Often they leave as destitute as when they entered. For several years the Community of Hope has provided a shelter for such families. The demands upon us have increased dramatically in recent months.

The families who enter the shelters are but a few of the households left homeless in the city. Most families are dismembered before they reach a shelter. Children are separated from parents, placed in homes of friends, relatives or neighbors or in foster care. The parents then separate to find whatever housing is available.

The fact is that without substantial housing subsidies most low-income people cannot afford to rent at market rates. There are virtually no rental agents who will accept from us and others, applications from

households dependent upon public assistance. The waiting list for public housing is years long.

We have entered a time when low-income parents are increasingly unable to provide housing for themselves with their children for no other reason than inadequate income. For years our older rental stock has been deteriorating faster than it has been restored. Owners and agents claim that they cannot collect enough rent from low-income people to meet operating expenses let alone debt service, rehab costs, and profit. Even so, poor people are willing to pay more than 50 percent of their income for inadequate housing rather than dismember their families.

In Washington the market rate for a two-bedroom apartment will exceed the cash income of a mother and three children wholly dependent upon public assistance. Many others with jobs have insufficient income to meet the standard financial qualifications—no more than 25 percent of income for rent and utilities—to enter into a rental contract. The backlog of court-ordered evictions is now so large, over 4,000, that the U.S. Marshals have taken the unprecedented action of accepting overtime wages from the landlords to evict families on Saturdays.

The result is that more and more families are needing to stay in the shelters provided by the city. There is more overcrowding and increased instability among families. The unacceptable reality is that children are being separated from parents and parents are denied the right to care for their own.

Family homelessness is much more than a housing problem. It threatens the social fabric and violates the moral sensitivities of every citizen. While we would never allow children to be forceably removed from their parents simply because those parents are poor, in fact, that is what we approve of by failing to provide the opportunity for housing to every family in the city.

Senator SPECTER. Reverend Nees, how frequent is this practice of accepting overtime wages from landlords by the U.S. Marshals to evict families? It sounds like something that is of questionable legality.

Reverend NEES. Well, that has occurred in fact in recent weeks.

Senator SPECTER. The whole point of the U.S. Marshal or any evicting authority is to be quasi-judicial and unbiased, and taking pay from the landlords, it is hard to be unbiased in the application of a public duty.

Reverend NEES. Exactly. And there are several levels in which I think that can be challenged.

Senator SPECTER. Has it been challenged?

Reverend NEES. Yes; in fact the city government has taken some action to challenge that but it seems that the Federal Government, particularly the U.S. Marshals are not particularly amenable to those processes. The mayor and others have come out opposing that process and I think it still remains a question of whether it will continue.

Senator SPECTER. I am told that it has been suspended; is that your understanding?

Reverend NEES. I understand that it has been suspended but the question is still there, whether or not it is an appropriate use of funds

from the private sector to pay for that. And the final answer is not in yet on that.

I suspect that it was suspended more because of publicity than because of some decision on the part of the U.S. Marshals that it was inappropriate. I think the outcry—but the fact, actually that is the tip of the iceberg, that is symptomatic of the deeper problem that we have. Even if we could deal with that problem, the reality would remain that there are over 4,000 court-ordered evictions pending and the question is how to deal with the reality of that large backlog.

Senator SPECTER. What do you suggest should be done with that problem? Because it is right on target with the issue of mortgage foreclosures. The only difference is that these are people who have leases as opposed to fee interest.

What do you suggest?

Reverend NEES. Well, it is extremely complex problem and there is no simple solution. It is like pushing on a balloon, you push on it one place and you are going to effect a hole in it. Certainly rent control legislation has some effect on that.

The landlords in our economic system are there to earn a profit on their investment and if you accept face value what we are hearing from investor-owned apartment buildings, there is a poor investment and for them it has got to make sense at a profit level in order to continue on.

Senator SPECTER. Are there any public funds available to help people out on a short-term basis then?

Reverend NEES. Yes, there are. A family would go to court, and few of them do, the problem is, often with the court procedures that most families do not know about or take advantage of the legal services provided. But there is a response to those families, a family can get, I believe it is 1 month's back rent paid one time a year. But many of these families, 4,000, are 5 and 6 months behind and the delinquency in some instances will run up into the thousands of dollars. And so there is not a response sufficient enough to deal with those large amounts.

Senator SPECTER. Reverend Nees, are many of the so-called street people, family people who were dispossessed?

Reverend NEES. It is hard to—I am sure that some of them are. But I think there are two distinct problems.

Senator SPECTER. There are two different problems.

Reverend NEES. Yes; I think so. I think we need to sort those out. The problem of the street people is obvious, I think we can see the people there. They are often traumatized, dependent people of one sort or another. And we have already been talking about the reality of the deinstitutionalization and how that has increased.

Senator SPECTER. The issue of deinstitutionalization has not affected as much what you are talking about?

Reverend NEES. Not as much. It does some. But for the most part, when we are talking in terms of homeless families, or families that have the capacity to be self-sufficient in the way that most people do not have, we have been working with families such as this for 10 years now and our conviction is and our experience is that these people do have

the capacity and many of them have been, and for the first time in their lives are finding themselves unable to provide decent and affordable housing. It is not because of psychological problems or addicted problems, although those experiences enter into it. But basically these are households, families in our society who can pay the rent if they have the money and maintain a household.

Senator SPECTER. You are on the President's commission?

Reverend NEES. I have been serving on the religious sector of the President's Task Force on Private Sector Initiative and it actually came to an end this past year. It was a brief attempt by the President to draw in private sector involvement in a variety of ways.

Senator SPECTER. When were you appointed to that position?

Reverend NEES. Well, during this past—during 1982 and the commission's work actually has commenced, has come to an end now.

Senator SPECTER. How long did the commission exist?

Reverend NEES. Just for a year.

Senator SPECTER. And what were its findings?

Reverend NEES. Well, I have not seen the final report. It was an advisory commission to the President and in terms of the private sector, religious dimension of that, I think it tended to be so confused and contradictory that I do not—there was one thing that happened, that a data base was developed of groups that were doing kind of programs across the country.

Senator SPECTER. Did the President's commission make recommendations, to your knowledge?

Reverend NEES. Well, I presume so. Although I am not sure, the word that we had was that the Presidential advisors would attend the meetings and they would take the word back to the President and he was going to translate that into some work, perhaps the state of the Union or legislative action of some sort.

Senator SPECTER. Were you on the commission itself?

Reverend NEES. No; I was on the private sector—I was on the religious sector. They divided up into various—they had a commission of appointed members and then they had various groups.

Senator SPECTER. Task force groups?

Reverend NEES. Task force groups, yes, and I served on the Religious Task Force group with representatives across the country.

Senator SPECTER. Did you make any suggestions to the commission as to what you thought should be done?

Reverend NEES. Well, I think that the religious sector, I think churches have enormous resources within themselves, financial personnel, to respond to the needs of the poor people in our country. And I think the problem is we do not have the structure, we do not have the ways of bringing those resources into places of need. And sometimes I do not think churches are motivated—

Senator SPECTER. What should the churches be doing, Reverend Nees?

Reverend NEES. Well, I think to begin with, the church has a prophetic place in society. I think the churches have a responsibility to

create a moral climate in our society in which the needs of the least and the last and the lost are not forgotten.

We are not paternally partisan politically but I think we have a responsibility to create a moral climate out of which our politicians will understand clearly that it is our first responsibility to care for the poor and that whatever else we can do, unless we do that, we are morally discredited as a country, and that is our first responsibility to create that moral climate.

Beyond that, to inventory our resources, the use of church buildings, the use of church funds, brought into—

Senator SPECTER. Are church buildings available to perform the service that Mr. Snyder was describing, being open for the homeless?

Reverend NEES. Generally not. There are several thousand churches in the District. And most of them could be used, the space could be used in one way or another, but few of them are.

Senator SPECTER. What else should the churches be doing?

Reverend NEES. I think the churches generally have enormous wealth. At least access to that wealth. Their members are involved in shaping public policy, their members are in the private sector on corporation boards. I think members of churches who—

Senator SPECTER. Should churches solicit contributions from their members for problems of the street people, the homeless?

Reverend NEES. Well, in fact in terms of housing one of the new ingredients that needs to happen is the creation of perhaps church-sponsored, nonprofit corporations like our own which is able to enter into the housing market and because of tax exempt status purchase buildings at—with mechanisms that we have created below market value. What that means is that we can provide housing below market rates by using our nonprofit status in a creative way. And there are some IRS tax codes which have not been used which could be used and churches could enter into the creation of corporate structures to provide low-income housing in a way that the private sector is unable to.

Senator SPECTER. The churches should actually do the building, you are saying?

Reverend NEES. Sure, that is correct.

Senator SPECTER. And many churches have done that?

Reverend NEES. That is right.

Senator SPECTER. What do you think will be the final upshot of the President's commission on the board?

Reverend NEES. The correct title of that is the President's Commission on Private Sector Initiatives.

I am not optimistic about it. There is another commission, I presume. I think I heard something about the Mission of the Poor but I have not been a part of that and I am not sure what that is about, in this instance. I am not optimistic about there is anything coming out of that that would be substantial.

Senator SPECTER. Are you on the Mayor's Commission on Homelessness?

Reverend NEES. Correct.

Senator SPECTER. What is that commission doing?

Reverend NEES. The mandate given it to us by the mayor has been to come to some clear understanding of the problem, to advise the mayor about possible solutions.

Senator SPECTER. How big is that commission?

Reverend NEES. I believe there are 12 to 15 members.

Senator SPECTER. And how often has it been functioning?

Reverend NEES. About 2 months, I think. About 2 to 3 months.

Senator SPECTER. Has it filed any report or made any recommendations to the mayor?

Reverend NEES. We have passed on one report to the mayor at this time which has basically to do with our recommendation regarding street people. I think the feeling generally is that some of the problems are very complex and defy simple solutions and we are trying to look at some of the systemic issues that create homelessness among families. Our feeling, I think right off the top, we were able to identify some things that we felt needed immediate attention in a part of the city with regard to welfare of the so-called street people.

Senator SPECTER. What suggestions have you made for immediate attention, sir?

Reverend NEES. Well, one of the first priorities was the shelter for women. Up until recently there has been—actually the city does not run any shelters. It is a misnomer to call Blair and Pierce School city-run shelters. That is a contract to the Council of Churches. The city provides the money under contract to the Council of Churches, so the city is not providing any direct services in that sense. It is all contracted out. But if they provided the money, we assume that they have some responsibility for oversight and the fact is that up until recently there has been no shelters for women, not city-funded shelters for women and the plight of women is as bad as it is for men and in some ways has been more desperate than the plight of men.

Senator SPECTER. So the city did respond by providing the funding for shelter for women?

Reverend NEES. As I understand it, as I—the information I have had over the last few days is what you have seen too, and I understand that another school will be made available—

Senator SPECTER. Is there anything else that you suggest that the city do on an immediate basis?

Reverend NEES. Well general oversight in the quality of services provided. We found out almost by accident in a recent meeting that the main shelter for men had been without hot water for the last 4 months. I just find that outrageous.

One of the problems was the lice infestation in these shelters that men did not want to go to the shelters because of the problem of lice infestation and I was told in one of my visits that they were unable to provide even basic sanitary care for these facilities because of money. I find that outrageous.

We ought to have, if we are going to provide a shelter, basic sanitation providing showers, I would think would be fundamental and how it went on for this length of time, I do not understand. There needs to be some general oversight into the use of—if the money is provided by public sector then we need to have some guarantee that those shelters are being run and I think we need some public baths.

In our agency we have people who come daily for health care. We have a health service and legal aid and so forth. But we have people who will never go into the shelter, who come to our facility just to bathe. Like European cities, I think the city ought to provide some baths where people can go during the day and clean themselves up and have whatever minimal services are needed for the care.

This is a copy of the first advisory report dated January 5 that the commission made available to the mayor. You are welcome to it.

Senator SPECTER. While that is coming up, what should the Congress be doing?

Reverend NEES. Well, the whole issue of homelessness needs to be dealt with at several levels. The micro level, and that is where I am working daily on one street and one block with a few buildings. But the macro level, of course, has to do with Congress and the bigger picture. We face some fundamental economic problems in our society as regards housing.

The reality is that low-income people can no longer afford decent affordable housing and without subsidies of some sort, the likelihood of families being able to provide housing for themselves in the future is slight.

Senator SPECTER. What do you recommend on that, more public housing, a voucher system? How would we approach it?

Reverend NEES. Combinations of all of the above, I suppose.

I think that there is a need for more public housing. Private housing, the private industry can no longer provide low-income housing. It cannot be built at a cost these days that is affordable by poor people. So the Government has to be involved in providing what is the basic rights.

Now, whether that comes out with a section 8 kind of program or voucher kind of program, you know, there are pluses and minuses in all of those and depending on a particular area, it would be different, I suppose.

Senator SPECTER. Reverend Nees, thank you very much for being with us today and for providing this testimony. We will make this first advisory report, of the mayor's Commission on Homelessness a part of the record.

[The report follows:]

FIRST ADVISORY REPORT, JANUARY 5, 1983

Recommendations for action from the Commission on Homelessness to the mayor:

1. The Opening of a city-operated women's emergency shelter at Bundy as soon as possible.
2. That the city-operated shelters be supplied immediately with sufficient blankets for each bed.

3. That the city-operated private and public shelters be directed to take immediate steps to sanitize facilities, equipment, and supplies to insure the elimination and/or control of lice infestation.

4. That the director of the city's shelters provide transportation from over-filled shelters to under-used shelters, and that this transportation be available 7 days a week during the normal intake hours until midnight.

5. That the commission authorize a representative to make regular, unscheduled visits to shelters to investigate the quality of care, and that shelter personnel be notified of the intention of the commission to monitor the shelter operations.

6. That during the winter months a daily report be made to a commission representative regarding the number of people in the shelters, and that in the event of overcrowding the city have immediate contingency plans for the overflow.

7. That within 1 week the commission be advised of the feasibility of the following additional actions to insure the health and safety of homeless people: (a) designated pick-up points throughout the city to receive and transport people to the shelters; (b) authorization of the police and/or others officially designated to remove people from the streets to shelters when the cold weather is life-threatening; (c) provide blankets, insulated suits as needed to those on the streets whose lives are threatened by the cold; and (d) a more visible communication effort to inform the city of the services being provided for homeless street people in an effort to dispel mistaken ideas about the scope of services provided and to encourage the use of services currently being provided.

8. A day-long men's shelter during December, January, February, and March to accommodate homeless men with minor winter illnesses.

JOHN F. KENNEDY COMMUNITY MENTAL HEALTH/RETARDATION
CENTER, PHILADELPHIA, PA.

STATEMENT OF A. ANTHONY ARCE, M.D., EXECUTIVE DIRECTOR

SUBCOMMITTEE ON PATIENTS' RIGHTS PITTSBURGH CHAPTER AMERICAN
CIVIL LIBERTIES UNION

STATEMENT OF ROBERT HICKEY, PH. D., CHAIRPERSON

Senator SPECTER. The next two witnesses we are going to hear in a panel form, Dr. Anthony Arce, who is executive director of the John F. Kennedy Community Mental Health/Retardation Center, Philadelphia; and Dr. Robert Hickey, chairperson of Greater Pittsburgh Psychologic Association and chairperson of the Subcommittee on Patients' Rights, Pittsburgh Chapter, of the American Civil Liberties Union.

Would you gentlemen come up here, please.

I think each of you gentlemen come from each end of the State of Pennsylvania and I have some special interest in what you have to say. Having heard the District of Columbia's point of view, we thought it might be useful to have some insights from Pennsylvania's problems of the street people, to which I could be a witness and attest personally, having been in both Pittsburgh and Philadelphia in the past several days and having observed the street people then and on many occasions in the past.

Dr. Hickey, let us start off with you, if we may. I know of your work as a psychologist and being chief of psychology at the Highlands Drive Veterans Administration Medical Center in Pittsburgh from 1971 to 1982 and of your work with the American Civil Liberties Union. I am pleased to hear your testimony.

Dr. HICKEY. My prepared testimony largely has to do with my experiences of efforts at decentralization.

Senator SPECTER. Dr. Hickey, your testimony will be made a part of the record in full. If you would prefer to summarize, that would be our preference.

Dr. HICKEY. OK. I guess my preference would be to say that I have been involved in several successful efforts of deinstitutionalization over the years. Deinstitutionalization I guess has contributed already in this case, of street people.

Senator SPECTER. Responsible deinstitutionalization?

Dr. HICKEY. Irresponsible.

Senator SPECTER. Do you think that the deinstitutionalization has worked out well overall, given the attendant problems of the street people?

Dr. HICKEY. Well, I mentioned in my prepared testimony that back in the 1950's I was working as attendant at a prestigious hospital for the mentally ill and I witnessed people there being beaten, shot, sexually abused, and generally dehumanized. And on my way home at night I would stop in Cambridge and have a snack at a cafeteria populated by the street people, the bag ladies, the bums, many of them hallucinating. It was my impression that they were better off.

Senator SPECTER. When was this?

Dr. HICKEY. It was in the 1950's.

Senator SPECTER. Prior to the decisions on the deinstitutionalization?

Dr. HICKEY. Right. Just shortly before and also before *Wyatt v. Stickney*.

Senator SPECTER. And you thought the street people were better off then. Do you still think so?

Dr. HICKEY. A lot of the people that I have known who have preferred to live on the street rather than in an institution, in a sense are like a lot of Patrick Henry's and somewhat reflect the testimony of your first witness. They would prefer freedom I think to being institutionalized.

Senator SPECTER. Well, their preferences should obviously be given great weight. Should they be determinative?

Dr. HICKEY. I am sorry?

Senator SPECTER. I say their preferences should obviously be given great weight, but are they equipped to take care of themselves, ask society to take care of them? I guess the answer to both questions is pretty clearly "no." So the issue arises, not whether we are going to relitigate the decision but it might provide some guidance for us in the future when we try to improve the lot of the individual, expand his constitutional rights, and provide minimal security, minimal restraints. But we have an era of street people that the community has not responded to with resources. The question is should there have been some correlative solution before the deinstitutionalization occurred?

Dr. HICKEY. I think in our country with our Constitution we have a sort of conflict between two very positive traditions. One is the tradition of helping those who cannot help themselves and the other is to protect

the individual liberties and choices of our citizens. So some combination of the two, I think. It is always a balance.

I think in any balance if you want to truly care for people you need to also respect them.

Senator SPECTER. So in retrospect, do you think that deinstitutionalization was a wise decision?

Dr. HICKEY. When it has been done well. It has worked out very well for the people I have worked with over the years.

Senator SPECTER. And when it has been done badly?

Dr. HICKEY. Then you have people freezing to death in the streets.

Senator SPECTER. And given the way it has been done, the facts of it, if you had to replay that decision, given your preferences, would you?

Dr. HICKEY. I would do it again.

Senator SPECTER. You would do it again?

Dr. HICKEY. Sure.

Senator SPECTER. What is your judgment as to the answer to the problem of the street people, Dr. Hickey?

Dr. HICKEY. I am not sure that I can talk about street people in general. I can talk about emotionally disturbed and mental handicapped people who find themselves in the street. I think, you know, first, the first answer, once people are in the institution or are in some kind of community treatment setting, is to help people learn how to live, to teach the skills that people need to get by in life. This can then involve a process where there is a steadily decreasing level of intervention and treatment and increasing independence on the part of the client. One kind of a program that has been very successful is the token economy program where people are reinforced for survival behavior, survivor behavior is in tough shape.

In the program I was involved in we borrowed the Fairweather Lodge concept and trained people, helped people how to live as a mutually supportive group. We would then help them to rent a house in a community and live together and share with continued support from the hospital, continued provision of medication, continued psychotherapy, and social skills training is needed but that need decreases as time goes on.

Senator SPECTER. Dr. Hickey, would you have any idea how many street people there are in the city of Pittsburgh?

Dr. HICKEY. No; I do not.

Senator SPECTER. Would you say it would be in the thousands?

Dr. HICKEY. I do not know.

Senator SPECTER. Would you have any idea as to how many of the street people of Pittsburgh are those who are having mental problems, as you describe them?

Dr. HICKEY. Before coming down here I checked with Fran Ulrich, who is the director of transitional services in Pittsburgh. His impression is that it is a very small minority of the street people who are deinstitutionalized. Pennsylvania has done a more responsible job of deinstitution than other States, at least that is Fran's feeling.

If you have other hearings I would suggest that you get Fran down here. He also suggested talking to the Sisters of Betheny who provide emergency housing for people in Pittsburgh. But he feels it is a very small minority.

Senator SPECTER. What has the response of Pennsylvania been, as you describe it, which is preferable to the response of other States on handling the problem of deinstitutionalization?

Dr. HICKEY. Pennsylvania has made an effort through the service units, through the clinics to find at least halfway houses for living arrangements. I know this has been a problem with some of the group homes, particularly in the Pittsburgh area. Transitional services. However, it is an example of a fine program where people are provided housing at first and then a diagnostic center where their ability to cope in society is evaluated, and then in-houses and then group apartments where there are counselors who help them to learn the skills they need to make it in society.

Senator SPECTER. Would you say that there are sufficient number of halfway houses to take care of the problems of the street people of Pittsburgh?

Dr. HICKEY. No; I do not think so. No; and besides, this refers to deinstitutionalization. This is a process that occurs in the hospital as discharge plans are made. I think probably one of the things that is most important is adding the discharge plan, particularly the person who has been deinstitutionalized for a long period of time, and then coordination with the support agency.

Senator SPECTER. Have you worked on such discharge plans in your own work?

Dr. HICKEY. Yes, I have.

Senator SPECTER. And did you ever face a situation where there were insufficient facilities to accommodate the person about to be discharged from the halfway house?

Dr. HICKEY. Oh, certainly. I would like to let you have a copy of some work that I did in Roanoke, Va., where we had some solutions to the problem, which because of—oh, bureaucratic considerations, are not possible apparently now but could be made possible again. There are increasing problems now with people seeming to be taken off SSI indiscriminately. People are going to be taken off welfare in Pennsylvania. That has already started and I know at the Highland Drive VA there are many people in the hospital simply because they cannot support themselves outside.

Senator SPECTER. What suggestions would you have, Dr. Hickey, as to how we could better address the problem of the street people?

Dr. HICKEY. Again, I think I have to talk about people with emotionally—emotional disturbances, the mentally handicapped rather than street people in general. I think that we need to look at the whole business of institutionalization, deinstitutionalization, I think we have to recognize that there are some people who need to be in institutions for relatively long time. It is important however that their rights be protected, that they have some leverage in bargaining, that they have a

voice in selection of their treatment plans, for example. But that the way you encourage people to develop programs, preparation for living in the community, use of day hospitals as much as possible, a substitute for hospitalization so that the dependency that comes from institutionalization does not add on to the emotional problems that are there in the beginning to make people less able to function and cope in society. A lot of the problem with the deinstitutionalized is that they spend 20 years not even opening the door for themselves, just living the life of the institutionalized and having, in a sense, a decision-free life.

So as much as possible, day hospital for institution, for those who are institutionalized prepare them for life in the community and then provide ongoing support for people in the community. Apparently research indicates that time-limited programs, halfway houses are only effective as long as the people are in the programs. So develop long-term sources of support, crisis intervention, social skills training, social network, people who are emotionally disturbed tend to have very few people to call upon in a crisis.

Senator SPECTER. When you talk about long-term support, how long do you need to provide the support on the average?

Dr. HICKEY. I do not know about average. Some people only need it for a month or so. I know other people who are institutionalized for a long time, I am sure will need it all their lives.

But that may be as simple as a day treatment center where people go in and socialize together, provide each other mutual support with a little bit of social skills training, is not expensive at all. But it is needed over the long haul.

Senator SPECTER. Dr. Arce, let us turn to you now, if we may.

You are executive director of the Philadelphia JFK Community Mental Health Center. You have a contract with the city of Philadelphia for a variety of purposes.

We have your record, your statement which will be made a part of the record in full. We appreciate your summarizing it and paying particular attention to the activities in the city of Philadelphia, particularly the problems of the street people.

Dr. ARCE. Senator Specter, I would first want to say that homelessness and chronic mental illness are not synonymous, though it is estimated that between 30 and 50 percent of the homeless are suffering from a major psychiatric illness. Homelessness is a social problem that requires a multifaceted solution.

For example, in early 1982 when a record cold snap hit the city of Philadelphia threatening the lives of our many homeless, a temporary emergency shelter offering only room and board was set up by the Department of Welfare. Within a week the shelter required psychiatric supports. Of the 200 people admitted, evaluated, and treated during the 9 weeks of the shelter's existence, 85 percent were diagnosed as mentally ill.

In general we are able to group the homeless into three major sub-populations: street people—those who regularly live on the streets; the episodic homeless—those who are sometimes domiciled and sometimes

on the street for extended varying periods of time; and the situationally homeless—those who do not usually live on the street but who as the result of an acute situational crisis find themselves without shelter. Many of these people, who face severe economic emergencies at this time, may be categorized as situationally homeless.

It is my experience that, the vast majority of the chronically mentally ill residents of the shelter were either street people or episodic homeless. These two groups are markedly different. The street people tend to be over 40 years old with histories of long-term hospitalization in State hospitals. This group is generally regarded as the "deinstitutionalized" population.

On the other hand, the episodic homeless tend to be younger, more recently identified, and commonly referred to as the young adult chronic patients. The episodic homeless have never been in a State hospital. They are a different kind of deinstitutionalized population because their treatment histories have always occurred within the community. Because of the more stringent requirements for hospitalization in State hospitals, they have rarely had access to that setting, but have instead had access to community services. This is a very difficult population to manage.

The two cited populations have been very clearly distinguished in the scientific literature, for example, recently by Pepper, Bachrach, and Lamb alone, with a number of recommendations for the kinds of services they need.

The chronic population generally thought of as the deinstitutionalized from the State hospital have rarely had their needs addressed. I ask permission to have this white paper published by the Joint Commission of Public Affairs of the American Psychiatric Association made part of the hearing record.

Senator SPECTER. We will take a look at that, Dr. Arce.

[CLERK'S NOTE.—The information appears at the end of Dr. Arce's testimony.]

Dr. ARCE. In this shelter population we diagnosed an entire spectrum of mental illness. Forty-four percent were diagnosed as schizophrenic and 30 percent had a primary diagnosis of a substance abuse, primarily alcohol.

Secondary diagnoses of substance abuse were prevalent so that about 51 percent of the total shelter population had a problem with alcohol or drug abuse or a combination thereof. There was also evidence of physical illness in 25 percent of the population examined.

A large number of people were actively symptomatic when they came to the shelter and improved when adequate medication was made available. In many cases medication obviated the need for hospitalization, either involuntary or voluntary. Significantly 6 percent of all the patients accepted the medication. It seems that this compliance rate is related to the offering of services in a relatively nonstructured and non-demanding setting.

The above observations clearly establish the need for adequate psychiatric input and access to adequate medical care for this population.

The most significant problem was finding appropriate relocation facilities. The inherent problems of our existing residential system became immediately apparent. There were not any residences available for people with mental symptoms whose behavior may be somewhat inappropriate, that is, perhaps destructive but not committable. There also did not seem to be residences for people loathe to surrender their personal freedom.

Senator SPECTER. When you talk about residences, that is the alternative to the institution?

Dr. ARCE. There is a need for a system of residences in the community to meet the varying needs of the homeless population, yes.

Senator SPECTER. Are there any at the present time?

Dr. ARCE. There are some.

Senator SPECTER. Many?

Dr. ARCE. There are some similar to community residential rehabilitation facilities that have just been established under Pennsylvania regulations.

Senator SPECTER. And how many people do they accommodate? How different are they from an institution?

Dr. ARCE. They accommodate between 8 and 15 people, depending on staffing, size, and servicing.

Senator SPECTER. And what are the distinguishing characteristics between that kind of residence and an institution?

Dr. ARCE. The individuals have a considerable amount of freedom, adequate support services in the community, linkages with mental health systems, and individual treatment plans.

The old institutions were simply warehouses. I was the director of one.

Senator SPECTER. So the difference is facilities and the services as opposed to being a public building with a staff?

Dr. ARCE. There is a permanent staff in these community residences, but not complete medical and psychiatric supports.

Senator SPECTER. Well, if you have those services in the old kind of an institution, would that have been adequate to avoid the court decisions, in your judgment, to be deinstitutionalized?

Dr. ARCE. I would doubt that. I think the problem of deinstitutionalization transcended the problem of whether adequate staffing existed. Certainly the lack of adequate staff compounded the move toward deinstitutionalization.

Senator SPECTER. What was the key factor, size?

Dr. ARCE. It was size, isolation from the rest of the community, a low level of stimulation, a generally degrading and dehumanizing environment, and a mob-type of approach to the individual.

Senator SPECTER. How many such facilities are needed, would you say, in the city of Philadelphia, to handle the kind of problem which is present here?

Dr. ARCE. Concerning the community residential rehabilitation services, I would not venture a guess, but they are only one type of facility. Other types of facilities could be set up which could accommodate

larger or smaller groups of people, with more or less staffing and support services, depending on the needs of the residents.

I chaired the American Psychiatric Association's Task Force on Community Residential Services which issued a report on the types of residential services from least restrictive to more restrictive that would meet the needs of this very population.

Senator SPECTER. What are the conditions of the State hospitals, Dr. Arce. Have they changed?

Dr. ARCE. The conditions in the State hospitals have generally improved. As the staffing ratios have improved within the State hospitals, they have become more treatment oriented.

It is my opinion that the major problem with deinstitutionalization was essentially that adequate funds for support services for the people sent out of the State hospitals were not made available for intercommunity services. Even after 20 years of deinstitutionalization, I would say that an average of only 10 percent of State funds earmarked for the care of the mentally ill are utilized for community services. This is the same percentage as 20 years ago.

Senator SPECTER. Are you saying that there are fewer dollars devoted now to the mentally ill for the State than were devoted 20 years ago?

Dr. ARCE. Yes; in proportion to the population. To the locus of the population there are fewer dollars now dedicated to the care of the mentally ill in communities than in State hospitals.

Senator SPECTER. Let me see if I understand you. You are saying, for example, in the State of Pennsylvania, there are fewer funds for the mentally ill in the State budget in 1983 than there were in 1963?

Dr. ARCE. No; there are more funds, but these dollars do not translate into more actual services, given inflation, and also the movement of the population.

Senator SPECTER. What do you mean by the movement of the population?

Dr. ARCE. Well, if you have a State hospital that has 10,000 people, and a budget of \$25 million, and you move 5,000 of those people into the community, leaving 5,000 people in the hospital, keeping the \$25 million in the State hospital, you have not moved the funds with the people. You have perhaps improved the quality of life and the treatment services in the State hospital for the 5,000, but you have abandoned 5,000 people to the vagaries of the community services.

Senator SPECTER. And the community services are inadequate, is that what you are saying?

Dr. ARCE. Yes; the support for community services is inadequate. It is not only a problem in Pennsylvania, but a problem nationally.

Senator SPECTER. Are any significant efforts being made on this problem, in your judgment?

Dr. ARCE. Nationally?

Senator SPECTER. Take it either way, nationally, statewide, citywise.

Dr. ARCE. Citywise, we now have, as you mentioned, a program for taking care of some of the homeless and some of the mentally ill. For some, we have a three-pronged service. They use a drop in center for a

24-hour stay, for those that find themselves without shelter. The center limited to 200 people, and it is filled very quickly. There is also an emergency shelter for approximately 50 people who are emotionally disturbed.

Senator SPECTER. So do you think the city has made some improvements?

Dr. ARCE. Some improvements.

Senator SPECTER. And how about the State?

Dr. ARCE. The State has not become very involved in the situation.

Senator SPECTER. How about the national response to your problem?

Dr. ARCE. I do not think there has been any national response to the problem.

Senator SPECTER. And what do you think should be the responses of the national, State, and city level?

Dr. ARCE. I think there is a need to realize the many facets of the problem. It is fallacious to assume that it is only the deinstitutionalized population that is homeless. The approach to homelessness demands a broader kind of approach than the approach to the institutionalized population. There is a need for the enunciation of a public policy to care for the chronically mentally ill, whether deinstitutionalized or not, and whether young or old, as well as the chronic patients.

There is a need for a national leadership which utilize the State governments. After all, of Federal money has shifted from direct Federal categorical grants to block grants, and it is now the responsibility of the State to allocate these funds.

Senator SPECTER. Do you disagree with that block grant approach?

Dr. ARCE. Not necessarily.

Senator SPECTER. Do you agree with it?

Dr. ARCE. I agree with certain aspects of it. I think the State is much closer to its own particular situation and given a reasonable attitude and a reasonable prioritization of the problems in the State that, yes, this is a more reasonable way to go.

Senator SPECTER. Dr. Hickey and Dr. Arce, thank you very much for joining us. I very much appreciate it. Dr. Hickey, we have your testimony and Dr. Arce, we have your testimony and the white paper published by the Joint Commission on Public Affairs of the American Psychiatric Association Board, and John A. Talbott, M.D., "Toward a Public Policy on Chronic and Mentally Ill," which I have just scanned, and which we shall make a part of the record.

Thank you.

[The information follows:]

STATEMENT OF ROBERT H. HICKEY, PH. D., CHAIRPERSON OF THE BOARD OF DIRECTORS, GREATER PITTSBURGH PSYCHOLOGICAL ASSOCIATION

I am a clinical psychologist engaged in the practice of clinical and consulting psychology in Pittsburgh, Pa. I am also chairperson of the Board of Directors of the Greater Pittsburgh Psychological Association, and, for over 11 years, have been chairperson of the Pittsburgh ACLU Committee on the Rights of Mental Patients. I am also on the professional advisory committee of transitional services, an agency that assists the deinstitutionalized to learn again how to live in the community. My doctorate in psychology is from the University of North Carolina at Chapel Hill. I was with the

Veterans Administration Department of Medicine and Surgery for 23 years, first as a psychology trainee, then as a staff psychologist, and finally as chief of psychology at the Highland Drive V.A. mental hospital in Pittsburgh. I administered the member employee program at the Salisbury, N.C., V.A. hospital, was patient government advisor at the V.A. hospital in Salem, Va., where I participated in establishing several deinstitutionalization programs including a network of "lodges" in which deinstitutionalized patients provided family settings for one another in houses they rented with our help in Roanoke and Salem. I have also participated in the so far most definitive research into characteristics of mental hospital programs that contribute to good post-hospital community adjustment, and coordinated the day treatment center for deinstitutionalized veterans in Southwestern Pennsylvania.

My interest in deinstitutionalization and patients' rights began, however, when, as an undergraduate in the 1950's at Boston University, I visited a number of mental hospitals, including the one so shockingly depicted in the documentary movie, "Titicut Follies," and worked as an attendant at a private hospital for the very rich and well insured. Each night on my way home from work, I would stop for a snack in a cafeteria populated by street people, some of whom were obviously psychotic and hallucinating. It was my impression that they were better off than the patients I observed being dehumanized, beaten, lobotomized, shocked and sexually abused at that prestigious hospital.

Things got gradually better over the years, of course, and I worked at many hospitals with staffs who were respectful of patients and worked conscientiously to help people reintegrate and move out of the institutions and we hoped, live happy and productive lives. We had some success with that in the 1950's and 1960's, even before *Wyatt vs. Strickney* and the concept of "least restrictive treatment setting consistent with responsible care." These efforts had to stem from our consciences and mutual support, because our efforts were more likely than not to be punished by administrators and entrenched staff who were unlikely to be pleased by anything that threatened the status quo and high average daily patient census.

Now, a few decades later, our sensibilities are offended and our consciences pricked by the seeming multitudes of street people, a minority of whom are deinstitutionalized mental patients, and deinstitutionalization is being blamed. Aside from the economic recession, irresponsible deinstitutionalization is mostly to blame. Five minutes does not allow time to delineate examples of responsible deinstitutionalization. With your permission, I would like to enter some examples of effective deinstitutionalization into the record, and I welcome your questions.

STATEMENT OF A. ANTHONY ARCE, M.D.

I am A. Anthony Arce, a psychiatrist and Executive Director of the John F. Kennedy Community Mental Health Center in center city Philadelphia. Besides private practice, my professional activities over the past 20 years have included clinical and administrative positions at county and state levels. Among them have been Director of State Aftercare Services in New York City and Director of Manhattan State Hospital. During the past year, the John F. Kennedy Center has been actively providing psychiatric services in support of the City's burgeoning efforts to care for its homeless, affording us an opportunity to initiate a detailed study of this population from both clinical psychiatric and service systems perspectives. Although our study is ongoing, we have accumulated sufficient preliminary data for some analysis.

I appear before you today in response to your invitation to testify on the plight of the so-called "street people" and on behalf of the American Psychiatric Association and the Philadelphia Psychiatric Society.

The spectre of the homeless is haunting every major American city. The constant presence of ragged, festering, sometimes hallucinating wanderers, is construed sometimes as an unwarranted eyesore, more often as a moral scandal. While it is true that large urban centers have always known the vagabonds, hoboes and derelicts who populate skid rows, what we are witnessing today is a new phenomenon in magnitude and heterogeneity. New York estimates it has 36,000 homeless people; Philadelphia, 5,000 - 10,000; Detroit, 8,000; Atlanta, 2,000; Phoenix, over 3,000 in summer and double that number in winter. The problem manifests itself in Seattle, Columbus, and New Haven to name only a few. There is hardly a metropolitan area that does not witness this shocking picture of human suffering.

The presence of large numbers of severely distressed, disturbed or disabled people on city streets is obvious to the

most casual observer. Their visibility is cause for acute concern to shoppers, businessmen, tourists, advocate groups, police, and the press. Such concern, while increasingly reflected in the media - such as last year's series of articles in the Philadelphia Inquirer and a recent television report on the homeless in our nation's capital - has yet to be translated into organized programs for assistance under the aegis of local, state or federal governments. Whatever care is being offered is provided by individuals and groups who volunteer their time and money to bring food and clothing to these unfortunate people in their usual haunts.

The actual magnitude of the problem, i.e., the precise count of the homeless population, is difficult to establish because of almost insurmountable methodological barriers. Estimates generally include only those persons who are visibly living on the streets or in designated shelters. However, there is reason to believe that significant numbers of our citizens may be in fact, virtually - homeless - those who are making do with makeshift accommodations in friends' apartments or flophouses, those who are making use of public campgrounds and tents, and those who are temporarily institutionalized in hospitals, jails, etc. but who, upon discharge, will be without a residence. Whether an accurate count of these real and potential populations has any utility is open to question. Given the social forces responsible for homelessness, the numbers can be expected to vary from time to time in relation to the magnitude of one or another causal factor at any point in time.

What are these social forces? The roads to homelessness are many. It is fashionable to attribute the problem of homelessness to the deinstitutionalization policies of the past two decades, i.e., the depopulation of state hospitals and the increasingly stringent admission criteria to these facilities. The solution to the problem, it is argued, lies in turning the clock back to old laws and old institutional treatment practices.

Although deinstitutionalization has certainly contributed its share to swelling the ranks of the homeless, former state mental hospital patients and the growing number of young adult chronic patients, are only one class of homeless.

The dramatic shrinkage in the low income housing market which accounts for 2 1/2 million people being involuntarily displaced from their homes; unemployment rates that approach Depression levels; and the drastic cuts in social welfare and disability benefits also contribute significantly to the problem. The shortsightedness of these policies for economic retrenchment, as well as the incredible bureaucratic difficulty in administering these programs, deserve special emphasis and attention. It is nothing short of a national scandal that in this most affluent and most enlightened of modern societies priorities are so arranged as to disenfranchise the least capable citizens from work, decent housing and appropriate care and support. A political and economic climate that marginalizes an ever growing segment of our society is at the root of this urban blight.

Homelessness is thus a social problem that affects a broad cross section of our citizenry, including the chronically mentally ill. Homelessness and chronic mental illness are not synonymous though it is estimated that between 30% to 50% of the homeless are suffering from major psychiatric illnesses. The solution to the problem of homelessness clearly does not lie within the purview of the mental health delivery system alone but requires interventions from other social welfare systems as well.

Given those caveats, what is the psychiatric profile of the homeless with chronic mental illness? In early 1982 when a record cold snap hit the City of Philadelphia threatening the lives of our many homeless, a temporary emergency shelter offering room and board was set up by the Department of Welfare. Within a week, psychiatric supports were added. Approximately 200 individuals were admitted, evaluated, and

treated during the 9 weeks of the shelter's existence. Mental illness was diagnosed in 85%, no mental illness was found in 15%.

In rather bold strokes, these are some of our observations:

The homeless can be grouped into 3 major categories:

- (1) "Street People", those who regularly live on the streets,
- (2) Episodic homeless, those who are sometimes domiciled and sometimes on the street, in each case for extended periods of varying length, and
- (3) the situationally homeless, those who do not usually live on the streets but as a result of some acute situational crisis find themselves without shelter.

The vast majority of the chronically mentally ill residents of the shelter fell within the first two categories. The young adult chronic patients, i.e., those under age 40, most of whom had never been admitted to a state hospital, clustered significantly in the episodic homeless category while the older ex-state hospital patients clustered significantly in the street person category. Whether this clustering reflects the progress of alienation as the individual moves through a series of failures in his/her encounters with the system over time, or the loss of coping skills through a combination of aging and the ravages of a chronic illness, or some other factors is a question that we hope to answer in our ongoing research efforts.

In any event, the difference between these two groups in clinical configuration, needs for services and the demands placed on the system are significant enough to require different approaches. The generic issues concerning the needs of the chronically mentally ill have been addressed by the Ad Hoc Committee on the Chronic Mental Patient of the American Psychiatric Association in a series of reports and recommendations for policy changes. More recently, the special needs of the young adult chronic patient have been addressed by Pepper, Bachrach, Lamb and others in the scientific literature.

The entire spectrum of major psychiatric illnesses was represented in the population under study. Schizophrenia was diagnosed in 44% and a primary diagnosis of substance abuse,

primarily alcohol, was made in 30% of the residents. However a secondary diagnosis of substance abuse was made in an additional number of cases. Thus in 51% of all shelter residents, the use of alcohol, drugs or a combination thereof was a major problem.

A large number of individuals who were actively symptomatic improved when adequate medication was made available. In some cases, the need for hospitalization was obviated. Significantly, 86% of all patients to whom medication was prescribed accepted them, a compliance rate that seems related to the offering of treatment in a setting with minimal structure and low demand.

The above observations clearly establish the need for adequate psychiatric input into any facility established to deal with the homeless. Evidence of physical illness, from mild to severe, was also found in approximately 25% of all shelter residents. Any facility offering temporary or permanent shelter to the homeless must also have access to suitable general medical care.

And finally, appropriate relocation of sheltered clients proved to be the most difficult problem of all. The inherent problems of our existing residential systems become immediately apparent. Not only were there no suitable homes for the mentally ill whose behavior was mildly inappropriate or disruptive but who did not meet criteria for involuntary hospitalization, but, more significantly, there were very few residences geared to individuals who were loathe to accept the loss of personal freedoms. To compound the problem, there were insufficient staff to plan for an assist in the careful integration of the patients into proposed residences. As a result a large number of placements proved highly unsatisfactory with patients either not reaching the placement or leaving it in less than a week.

To summarize, our shelter experience has demonstrated that:

1. The homeless and the homeless with chronic mental illness are not one and the same.
2. Approximately 60% of all the homeless have diagnosable and treatable mental illness.

3. The homeless mentally ill constitute a heterogeneous population with a wide range of needs.
4. The notion that the homeless may not "want to come in" is a myth.

The homeless and the homeless mentally ill, by and large, are not social isolates by choice but are victims of a system which fails to integrate survival and therapeutic imperatives. The long-standing fragmentation of responsibility for meeting the needs of this variegated population among several jurisdictions in government, each with its own regulations and eligibility requirements, insures insurmountable service gaps at the provider level.

5. The indispensable first step in reaching the homeless is the provision of graduated levels of refuge which vary in the degree to which demands for conformity are placed upon the residents. Consent to and engagement in therapeutic services appear to be related to offers of treatment in settings with minimal structure and low demand wherein the preservation of dignity and personal freedom provide the basis for trust.
6. There is a clear need for permanent emergency shelters with adequate general medical and psychiatric supports.
7. There is a need for liberalizing civil commitment statutes (with appropriate safeguards to insure the preservation of civil rights) to enhance the capability of the mental health delivery system to provide adequate care for the mentally ill.
8. There is a need to develop a rational system of community residential services to serve the needs of the variegated population of chronic mental patients.
9. There is an urgent need for a public policy and enabling legislation that address the plight of the homeless through the integration of health, mental health and social welfare resources to create comprehensive systems of care for this population.

Thank you for allowing me the opportunity to appear before this distinguished Subcommittee to share with you my observations and experiences. I look forward to continuing to work with you and the Congress in the formulation of public policy which addresses the needs of the homeless populations in our nation.

TOWARD A PUBLIC POLICY ON THE CHRONICALLY MENTALLY ILL

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This report is a summary of the work of the APA Ad Hoc Committee on the Chronic Mental Patient, which Dr. Talbott chairs, a complete version of which has been published as "The Chronic Mental Patient: Problems, Solutions and Recommendations for a Public Policy," Washington, D.C., APA, 1979. Although the author bears responsibility for the contents, he acknowledges the great contribution of the entire Committee on the Chronic Mental Patient and the participants in the APA Conference on the Chronic Mental Patient, held in January, 1978, in Washington, D.C.

The definition of chronic mental patient is that used by Leona Bach-

rach—"those individuals who are, have been or might have been, but for the de-institutionalization movement, on the rolls of long term mental institutions, especially state hospitals." ¹

The material in this White Paper was presented at the 1979 Annual Meeting of The American Orthopsychiatric Association. It has been edited by the American Psychiatric Association's Joint Commission on Public Affairs as part of its mandate to widely disseminate information about the critical needs of the chronically mentally ill as stated in the "Call to Action" adopted by the Association's Board of Trustees in December 1978.

Introduction*

State mental hospitals in the United States reached their maximum census of 550,000 in 1955. Thereafter their population steadily and dramatically declined to its current low of 180,000. The reasons for this decline include: (1) the development of the community mental health philosophy that it is better to treat mental patients in the community than in institutions; (2) technological advances, especially the introduction of new psychopharmacologic agents; (3) the increasing emphasis on patient rights by legal, legislative, and judicial forces; and (4) the substantial shift in the economic responsibility for the several million chronic mentally ill patients from the states to the federal government (through Supplemental Security Income [SSI], Medicaid and Medicare funding) as patients are discharged from state hospitals to nursing and to board and care homes. The mandated but unplanned movement of treatment and care for these people from hospital to community settings has been labelled deinstitutionalization. Deinstitutionalization means both the discharge of patients from hospitals into community settings and the reduction in admissions to governmental hospitals of certain patient populations, especially the elderly and those in need of purely "custodial" care.¹

By 1975, it had become clear in many American communities that deinstitutionalization was not an unqualified success. The media called attention to the wretched conditions in which many of these discharged patients lived²; some psychiatrists condemned the movement as a "national disgrace"³; state and local governments investigated the lack of services available to these patients⁴; and communities where hundreds of these patients had been "dumped" protested.⁵ The overutilization of crisis services by chronic patients became so serious that the Emergency Services Committee of the New York County District Branch of the American Psychiatric Association (APA) urgently requested the APA to study the problem and to propose solutions.

Since 1975, several publications have documented the impact of deinstitutionalization⁶ and have provided some guidelines for treatment of the chronically mentally ill.⁷⁻¹¹ This paper draws upon these contributions, as well as the three years' work of the APA Committee on the Chronic Mental Patient,¹² and provides a summary of the problems, solutions, and recommendations for a public policy regarding the chronic mentally ill patient.¹²

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** Drs. John A. Talbott, Chair, James T. Barter, Donald Hammersley, Maurice Laufer, W. Walter Menninger, Arthur T. Meyerson, Mildred Mitchell-Bateman, Lucy Ozarin, John Spiegel, Harold Visotsky, and Mr. Samuel Muszinski.

Critical Questions Concerning the Chronic Mentally Ill Patient

Who are the
Chronic Mentally Ill Patients
and where are they? ^{13,14}

In order to construct a map of chronic mentally ill patients, it is necessary to establish some operational definitions. Chronicity is used for an illness lasting "a long time," interpreted by some as hospitalization for one or two years or the presence of a major psychosis (e.g., schizophrenia) for the same time period. Chronic disability, on the other hand, is defined as eligibility for SSI. While Bachrach's definition of the chronic mental patient¹ is descriptively ideal, no statistics are available on "those individuals who are, have been or might have been, but for the deinstitutionalization movement, on the rolls of long term mental institutions, especially state hospitals." So a reconstruction is necessary.

How many chronic patients are there in the United States? There are 1,100,000 schizophrenics, 180,000 of whom are in hospitals and almost a million are in the community. There are one million elderly people in institutions, mainly state hospitals and nursing homes; 750,000 have psychiatric diagnoses. Also, there are one million psychotic elderly persons living in the community. Of all the severely mentally disabled (e.g., receiving SSI benefits),

1.1 million are housed in institutions and 3.1 million are not. Thus, there are between two and four million chronic mentally ill people in this country.

The locations of these patients have changed as deinstitutionalization has progressed. In the late 1950s and early '60s, over 65% of discharged patients returned to their families: only 20-25% lived alone or were referred to nursing or boarding homes. As the deinstitutionalization movement proceeded, the proportion of patients who were discharged to live by themselves or in nursing or board and care homes increased until currently only 23% return to their own homes.

The level of functioning of discharged patients is measured by several indices including: readmission rate, presence of symptoms, employment record, social isolation, and participation in after care. Before deinstitutionalization, only 25% of hospital admissions were readmissions, but that proportion had increased to 64% by 1972. Only one-third of all deinstitutionalized patients are asymptomatic, another third are mildly symptomatic, and a third are severely symptomatic. Although 30-

50% of discharged patients return to work, 70% of them return to a less skilled job and after a year, only 20-30% of discharged patients live in total isolation, 50% in moderate isolation, and only 25% in a family setting.

Furthermore, no more than 50-70% of discharged patients receive any after-care, only 50% continue their medication as prescribed, and no more than 25% are followed in regular after-care programs for more than one-two years.

What are the needs of Chronic Mental Patients? ^{14,15}

The needs of chronic mentally ill patients far exceed those of acutely ill patients. In addition to the generally available psychiatric services, they should have access to 24-hour, seven-day a week crisis services; programs featuring instruction in the skills of everyday living; vigilant medical attention since they are more prone to medical illness and are less likely to seek medical attention.

Housing is a more critical issue for this population, and requires a spectrum of graded living alternatives, from 1/4-way houses to independent living arrangements. This range is seldom available, and its absence has resulted in inappropriate placement of many patients, particularly the elderly, in nursing homes. Chronically ill patients are more likely to lack financial support and need employment opportunities (espe-

cially part-time jobs), vocational rehabilitation, and welfare. Those who cannot work full-time need help in developing meaningful daytime and evening activities. Social contacts, socialization, and the kinds of counseling and caring which a case management or monitoring system can provide are critical needs. In addition, counseling and supportive services to help family and friends cope with problems of chronic disability are rarely available.

Successful community programs for chronic patients must provide all of these services. Currently, there are serious deficiencies in all of these areas. For example, in 1974 there were only 232 halfway houses in the entire United States, with provisions for only 9000 ex-patients, or 1% of the schizophrenics residing in the community.

What programs work best for Chronic Mental Patients? ^{16,17}

Successful programs for chronic mental patients include hospital programs which prepare patients for discharge and community programs which provide supportive services. A prototype of the preparatory programs has been described by Paul and Lentz.¹⁶ It emphasizes a social-learning approach that utilizes behavioral modification, training in the skills of everyday living, and social and vocational rehabilitation. Results of the intensive four and one-half year program demonstrate that about 10% of

patients receiving this preparatory program were rehospitalized, compared to 30% of the control group receiving milieu therapy and 50% of patients receiving traditional state hospital treatment.

A good example of a community program is Fountain House in New York City. Fountain House combines several elements necessary to ensure chronic patients' survival in the community, including: inexpensive apartments, job training, job placement in low-stress em-

ployment opportunities, psychiatric coverage, and many social and recreational activities. The rate of rehospitalization of ex-patients in Fountain House's programs is significantly lower than that of controls: 17% after six months (vs. 37% of controls), 38% after two years (vs. 60%), and 53% after five years (vs. 70%). Fountain House members also stay in the community twice as long as their matched controls.

A model program at Mendota State Hospital, described by Stein and Test,¹¹ spans both hospital preparation and community supports. This program combines psychopharmacology, a high staff/patient ratio, a wide variety of services, and training in every-day living. Outcome studies demonstrate that the patients treated in the experimental program spend less time in the hospital and earn more money while in the community than the control population, that the quality of life of the experimental program patients is no worse outside the hospital than in, and that the self-esteem of the two groups and the burden to their families is similar.

Successful programs for chronic patients offer a variety and continuum of services which maximize individualized care and provide for easy access, entry and reentry to services as well as crisis responsiveness. These programs have good leadership from persons who know what they are doing, who are dedicated to chronic mental patients, and who can appreciate small progress in their patients. They usually employ aggressive outreach and effective patient-monitoring and patient-advocacy systems. Administration is well-structured, both vertically to governmental agencies and horizontally to other agencies. They have stable financial and community support and good systems for accountability and responsibility. Finally, and significantly, they manage to keep in view all those elements necessary for the treatment and care of chronic mental patients, including: symptomatic behavior, family and community involvement, social and interpersonal skills, and meaningful vocational rehabilitation.

What are the obstacles to providing successful treatment for Chronic Patients?^{18,19}

One of the most critical obstacles to applying the lessons learned in providing successful programs for the chronically mentally ill is attitudinal. Patients, families, community leaders, elected representatives, community members, and health professionals have negative attitudes towards this population. Chronic patients are seen as difficult to treat, uninteresting, frightening and bizarre. The poor records of both institutional and community programs in coping with chronic patients reinforce these attitudes.

There are legal and ethical obstacles to the successful treatment of chronic patients. Recent legal trends

supporting informed consent, competency, the right to refuse treatment, and the increasing assault on involuntary commitment, place barriers in the way of the patient's rehabilitation. In somewhat the same way, the plethora of regulatory agencies, each with its own accreditation, monitoring, and paperwork, tends to foster ineffective treatment.

The administrative structure of mental health services also poses a serious obstacle to rehabilitation of the chronic patient. Responsibility for chronic patients is diffuse and divided among state, county or city, and voluntary agencies, as well as among agen-

cies primarily concerned with medical care, social services, and supportive services (housing, income, etc.). Each agency has its own standards and qualifications for service, further compounding the problem of providing patients with what they need most. Evaluation of services and partisan, jurisdictional, and professional politics hamper efforts to provide good treatment and care.

Funding poses monumental problems for the care of chronic patients. In addition to fragmentation of funding and different eligibility rules in different governmental agencies, both governmental and private insurers have long discriminated against the chronically mentally ill. Thus, Medicaid does not reimburse state or private mental hospitals, and private insurers set limits on both inpatient and outpatient which preclude long-term care.

The lack of integrated community

support and care programs represents another serious obstacle. We have multiple systems, with multiple funding sources, multiple levels of oversight and planning, and multiple levels of accountability. In addition, all divisions of government contract for services by local entities and operate their own competing services. This conflict of interest often results in predictable cuts of services in community programs in periods of economic scarcity.

Yet another obstacle to successful programs is the lack of personnel trained in the rehabilitation-resocialization model. Although psychiatric and medical care are important to this population, attention to skills in everyday living and vocational and social treatment needs are equally important but are woefully lacking in the mental health system.

Economic issues concerning Chronic Mental Patients^{20, 21}

Health accounts for 9% of America's gross national product (GNP), and 15% of that is allocated to mental health services. The direct costs of mental illness, that borne by institutions and practitioners, were 14 billion dollars in 1974 or 1% of the GNP. Most (71%) of this sum went to institutions such as nursing homes (30%), state and county hospitals (23%), and general hospitals (11%). Only 8% was allotted to private psychiatrists and 5% to free-standing outpatient clinics. Indirect costs of mental illness, such as labor and production loss and public assistance to the mentally ill, account for an additional 20 billion dollars. The total for mental health, using 1974 figures, comes to at least 34 billion dollars, of which 87% can be attributed to the treatment and care of chronic patients.

It is not easy to determine whether it is less expensive to treat chronically ill

patients in the hospital or in communities. Sharfstein,²² who followed a single patient for 15 years, found that for the first three years, the costs were equivalent but subsequent community care was less costly. Stein, et al.²³ demonstrated that community care was 10% more expensive. To state departments of mental hygiene, however, costs appear to be lower in the community because inpatient costs include non-psychiatric life-support (food, shelter, and clothing) and general medical costs which are provided to outpatients by federally-funded Medicaid and SSI as well as extended families or private organizations. It should be noted that while direct treatment costs are greater in the community, every other cost (indirect treatment, law enforcement, maintenance, family burden, etc.) is lower. In addition, patients in community-based programs have earnings double those of

a control group, so the final tally demonstrates that community care costs \$400 less than the benefits derived by patients in such settings.

In planning for a possible national health insurance scheme, it will be necessary to differentiate between the services that will be reimbursed (such as diagnostic and treatment services; home health, day care, and outreach services; the costs of medication, etc.), and supportive services (such as vocational, educational, housing, transporta-

tion, homemaking, meals, chore services, protective services, and maintenance). Currently, in order to obtain supportive services, mental health professionals and chronic patients participate in what can best be described as a "scrounging system," which only is marginally effective. Planning for any future national health insurance must consider the special problems of reimbursing both direct and supportive services for chronically ill patients.

Case Management ^{24, 25}

As opposed to countries like the USSR, where there is a single service system, the United States has spawned a multitude of services which require coordinators to assist patients who are unable to negotiate the various systems by themselves. Case management is one method for helping patients find their way among the multitude of services. The concept of some type of patient general practitioner has existed for years in medical practice. Only recently has it been recognized as a useful device in the general human services field. When families are available, they usually carry out the case management function. But even competent families are often limited in their

capability to deal with complex systems. When competent families are not available, social workers replace them. Recently, a new profession or paraprofession of case management has been advocated which may, however, be redundant considering the rich array of professionals and paraprofessionals now working in the field of mental health. Others have experimented with the use of the therapeutic team, rather than any individual, as a case management system. Nevertheless, some form of case management is necessary for severe disabled chronic patients. This system should include an up-to-date treatment plan, active participation of the patient, and clearly-defined goals.

Levels of governmental responsibility ^{26, 27}

In colonial America, the chronic mentally ill simply wandered about. By the mid-eighteenth century, they began to be kept in almshouses and poorhouses. By the middle of the nineteenth century, Dorothea Dix's efforts led to their care in mental hospitals administered by state governments. The federal government also has administered some services to some chronic patients, either through direct provisions of care as in

VA and Armed Forces hospitals and community mental health centers or through funding (Medicare, Medicaid and SSI). Through the years, responsibility for the chronically ill has remained divided and poorly defined with respect to coordination, continuity, implementation, monitoring, and evaluation of care. There is no single system of care; instead, there is a non-system which cries out for a single point of responsibility

and authority for the chronic mental patient. Administrative structure must be reorganized and clarified, both vertically with respect to federal, state, and local agencies; and horizontally with respect to interagency referral, case management, and budgetary considerations. In-

tergovernmental conflict of interest, in both directly providing and coordinating or contracting services, must end. Finally, social services must become part of the formal structure in local mental health administrative agencies.

The Rights of Chronically Ill Mental Patients ²⁰

Chronic mental patients are discriminated against as much or more than other disadvantaged groups, such as the mentally retarded, welfare recipients, or prisoners. Even acutely ill mental patients are subject to less bias by Medicaid and other funding sources, in housing, etc. The same insurance reimbursement, housing opportunities, health care, and right to treatment should apply to chronic patients in the community as it does to acute patients

or to chronic patients in institutions. Commitment to hospitals must involve due process and legal ombudspersons. While the individual patient's confidentiality should be respected, the patient's right to assume that adequate information will be exchanged to ensure continuity of care is also vital. Institutional peonage and discrimination against chronic mental patients in employment should cease.

A Public Policy on the Chronic Mental Patient

To fulfill the needs of the chronic mental patient, this nation must adopt a public policy that specifically and adequately cares for these people. This policy must include:

- (1) public sensitivity and financial commitment to a system of graded and comprehensive opportunities and services;
- (2) designation of clear responsibility for providing services at appropriate levels of government;

- (3) full civil rights for the mentally ill;
- (4) a reform of funding mechanisms; and
- (5) adaptation in the delivery of services to meet the cultural values and perceptions or needs of various ethnic, minority and subcultural groups.

Specific recommendations can be made in several areas to accomplish these critically important goals.

Psychiatry's Role

Since care of chronic mentally ill patients is a public health responsibility, it is incumbent upon psychiatrists and other physicians to take an active role in attending to the needs of this population. Although psychosocial problems are more obvious, the medical and psychiatric needs of the chronic patients also require vigilant monitoring. In

addition, psychiatrists have a responsibility for the development of comprehensive services for the chronically mentally ill and should be involved at all levels in program planning, public education, training, and research related to preventive care and rehabilitation services.

Community Education

An intensive effort should be undertaken to inform the public of the needs of the chronic mental patient and

how to meet them. Community education must be oriented towards increasing the visibility and status of programs

for chronic mental patients. A major effort should be undertaken to develop a

constituency for these patients.

Research

Greater emphasis on research in chronic mental illness is needed, including: epidemiology, etiology, therapeutic methods and outcome, and service delivery. New research should be undertaken in family care, in the

comparison of institutionalized and deinstitutionalized populations, in criteria for deinstitutionalization, in the definition of the skills, process and tasks of case management, and in issues relating to confidentiality.

Training

Expanded training programs for professionals and paraprofessionals in skills appropriate to the needs of chronic mental patients is imperative. These programs should emphasize the community rehabilitation model and interdisciplinary efforts should include teaching about strength-assessment and skills of everyday living, training in geri-

atrics, and working in nursing homes. Funding should also be provided for retraining institutional staffs for community care. Residency training programs in psychiatry should include the care of chronic patients. A program for volunteer case aides should be established.

Continuity and Provision of Services

The barriers should be removed which currently limit the access of chronic mental patients to the full range of medical, psychiatric, rehabilitative, income maintenance, social, employment, and related opportunities in the least restrictive setting. All systems of

care should be continuous between institutions and local programs; well-developed systems of inservice program referral should be established; and a system of case management based on a comprehensive treatment plan should be constructed.

Financial Issues

As a long-term goal, programmatic funds should flow from the federal to the state level and should be earmarked for the chronic mental patient where possible. On the federal, state, and local levels, structures should be created to provide oversight of legislation and regulations which have an im-

pact on chronic mental patients. HEW should perform a national survey of Medicaid and Medicare in order to determine current inequities and should help establish national parity. Medicaid, Medicare, and future NHI should not discriminate against the chronically mentally ill as a class in any way, and

such insurance should include a full range of inpatient, day treatment, and outpatient services encompassing periodic medical and psychological evaluation and treatment, resocialization, and rehabilitation. Any future NHI should include cost-effective financial incentives to encourage professionals to care for the chronic mental patient in the least restrictive setting fostering full rehabilitation. Fiscal incentives to unnecessarily restrictive settings such as nursing homes and mental hospitals

should be eliminated. All CMHC's should provide comprehensive services to this population, and a federal technical assistance program should be developed to help localities develop programs for chronic patients. Funding mechanisms should not penalize states or localities for moving individuals out of the service system, and priority should be given to proposed systems which ensure that money follows the chronic mentally ill patient.

Administrative Issues

As long-term goals, the federal government should establish national policy, should set standards, and should take responsibility for leadership and advocacy of care of the chronically ill mental patient. State governments should carry out leadership and planning functions, should distribute federal monies, and should designate local authorities to have programmatic responsibility. Local authorities should designate specific local entities to perform program activities and to provide a holistic, integrated program for chronic mental patients. Also, there should be a federal oversight mechanism, such as the Select Committee on Aging, to oversee federal legislation and regulations regarding the chronic mental patient. Each state should have an office to plan

and support services for chronic patients. The local health planning body should carry out clinical integration independent of any care delivery system of its own which might represent a competitive interest. Accountability and evaluation of services must be assured. Existing resources should be used, with special concern for patients' families instead of building a whole new network of services and programs for chronic patients. States should be discouraged from developing new state-owned and operated facilities for chronic patients and should be encouraged to phase out unneeded, existing facilities. Finally, the federal government should eliminate state or regional options in the use of essential funds.

Civil Rights

There should be federal legislation or regulations to: (1) prohibit discrimination against chronic mental patients in employment and housing; (2) endorse the right to adequate treatment for both voluntary and involuntary patients in the least restrictive setting; (3) protect confidentiality while allowing access to relevant information for legitimate treat-

ment, planning, and research; (4) develop and fund an advocacy system independent of service provision to ensure implementation of patients' rights; and (5) prohibit zoning discrimination against the mentally ill. A Bill of Rights for mentally disabled patients living in the community should be enacted.

Summary

There is no more urgent mental health concern than the needs of chronically ill mental patients who suffer from severe persistent or recurrent mental illness with residual social and vocational disabilities. The deinstitutionalization programs of the past decade and the continuing prevalence of high risk populations that generate chronic mental patients have created a national crisis concerning the care of these patients.

This contribution has summarized the most significant problems of chronically ill mental patients. It answers the questions: who and where they are; what are their needs; what programs are successful for them; what are the obstacles to successful programs; what are the economic issues affecting chronic patients; what sort of case management is needed; what levels of government should be responsible for what functions; and what are the rights of chronic patients.

This contribution has also made recommendations basic to the development of a public policy for the chronically ill mental patient. These recommendations are in the areas of psychiatry's role, community education, research, training, continuity and provision of services, financial issues, administrative issues, and civil rights. We call on all governmental and professional bodies to consider this problem as a high priority and to take definitive action to meet this national crisis.

The report of the Conference on the Chronic Mental Patient, "The Chronic Mental Patient," contains detailed discussions of the subjects outlined in this paper. The book is available for \$11.00 per copy (APA Publications Sales, 1700 18th St., N.W., Washington, D.C. 20009).

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

STATEMENT OF DR. IRENE SHIFREN LEVINE, PH. D., SPECIAL ASSISTANT
TO THE ADMINISTRATOR

ACCOMPANIED BY:

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PREPARED STATEMENT

Senator SPECTER. I would like to call on Dr. Irene Shifren Levine and James Buford. Dr. Levine is the Special Assistant to the Administrator, the Alcohol, Drug Abuse, and Mental Health Administration.

Welcome.

Mr. Buford is the director of the Department of Human Services, District of Columbia, and we welcome you here.

Dr. Levine, let us start with your testimony, if we may.

Dr. LEVINE. OK.

I am here to present written testimony that was invited to be presented by Dr. Mayer, the Administrator of the Alcohol, Drug Abuse, and Mental Health Administration.

Senator SPECTER. Yes; that testimony will be admitted fully, and we would appreciate if you would summarize that for us, leaving a maximum amount of time for questions.

[The statement follows:]

STATEMENT OF WILLIAM MAYER, M.D.

It is not possible to provide accurate national data on homelessness. But we do know that the homeless population in this country is not a homogeneous one; that it includes runaway children, immigrants, migrants, so-called bag ladies, the recently evicted, certain numbers of the unemployed, battered women, and an over-representation of minorities. We also know that the problems and characteristics of this population vary according to locality. Despite our lack of data, we can say with some certainty that a significant segment of the total homeless population suffers serious and persistent alcohol, drug abuse, and mental health problems.

I recently visited Los Angeles to learn about one of a growing number of mental health programs that has begun to work with homeless people in the city's Skid Row areas. It has been estimated conservatively that between 35 and 40 percent of those homeless persons have a primary alcohol, drug abuse or mental disorder. Similar estimates reported nationally have led to our Agency's concern and our becoming involved with the issue.

I should point out that the mission of the Alcohol, Drug Abuse, and Mental Health Administration is primarily one of research. In addition, the Agency provides a national focus for the Federal effort that deals with health problems and issues associated with the use and abuse of alcohol and drugs, and with mental illness and mental health.

To accomplish this mission, our Agency conducts programs of research and training, as well as data collection and information dissemination. We also provide program expertise and technical assistance in response to Federal, State, local, and private organizations on matters related to their alcohol, drug abuse, and mental health concerns.

The mission of ADAMHA has changed from earlier years when the three Institutes that comprise our Agency--the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, and the National Institute of Mental Health--administered support to States and localities for treatment services.

The Alcohol, Drug Abuse, and Mental Health Services Block Grant provides funds to States to assist them in fulfilling their responsibilities for providing services to the chronically mentally ill. With the \$432 million provided under that program in Fiscal Year 1982, States have the leverage to

assure that local authorities and agencies provide services to the chronically mentally ill.

Our Community Support Program, in which you have expressed interest, is a Federally-supported demonstration program designed to help States and localities improve opportunities and services for their residents who are chronically mentally ill, and to assist in marshalling community resources to aid in successful de-institutionalization. Specifically targeted are those "severely mentally disabled adults whose primary disability is emotional and for whom long-term 24-hour nursing care would be inappropriate."

It is estimated that there are between 1.5 and 2 million chronically mentally ill persons nationwide. We do not know what portion of that population is homeless, but we do know that approximately 65% of the chronically mentally ill live with their families after discharge from a hospital.

Homeless people who are chronically mentally ill suffer many difficulties. These include recurring problems in meeting basic survival tasks; difficulty with the tasks of daily living; extreme vulnerability to stress; inability to develop or sustain social networks; lack of motivation or ability to seek the help of human service workers. Their problems cannot usually be remedied by short-term treatment.

Changes over the last two decades in treatment of the chronically mentally ill have brought about more humane and effective care. For example, the introduction of psychotropic drugs has enabled many people with seriously disabling psychoses to function more independently. The number of patients who can live successfully outside the hospital has increased greatly. Fewer need to remain hospitalized for long periods of time.

Another major development in treatment is the result of a philosophical shift which emphasizes the values of the therapeutic community and community psychiatry. The use of restraints and seclusion has been minimized, open door policies have been adopted, and barriers lessened between hospital and community. It was recognized that institutions too often tended to perpetuate the dependency, hopelessness, and bizarre behavior that they were trying to cure.

As experience proved the value of the community approach, pressure to move hospitalized patients into the community grew. This was reinforced by

court rulings and legislation which established important precedents, such as the right of mental patients to safeguards against involuntary commitment, and the right to treatment in the least restrictive setting. Furthermore, as the costs of psychiatric hospital care spiralled upward from \$2 a day in 1950 to \$58 in 1977, the States had strong economic incentives to reduce their State hospital populations rapidly. Hence, developments in technology, changes in professional practice, newly enacted laws, and altered public policy heralded a marked shift during the '60s in the locus of care: from institution to community, from inpatient to ambulatory facilities. In 1960 there were 535,000 psychiatric patients in State hospitals in this country. By 1980 the number had dropped to 137,000.

The deinstitutionalization movement has resulted in real gains. People who might otherwise have been confined to institutions for life have returned to their families and to productivity in the workplace, and have availed themselves of mental health services in their communities. Others have been fortunate enough to find placement in community residential treatment programs that provide sufficient structure so that they too can live with some degree of autonomy and independence. The principles of community mental health continue to shape approaches to mental health treatment for all patients.

While the reform efforts of the '50s and '60s sought to provide alternatives to large State institutions, new issues have arisen from community placement. Some people are lost in the cracks of fragmented Federal, State, and local service delivery systems and return to the hospital. Others simply become marginal or lost and wandering members of society, without appropriate social supports. They are often highly visible in our communities, among the homeless, the "street people."

The design of the Community Support Program had emerged from a series of working conferences through which the National Institute of Mental Health sought advice from a broad constituency of leading State and local mental health and human service administrators, professionals, and citizen and consumer advocates, on how to respond to growing national concern about inadequate community services for people who were being diverted or discharged from inpatient facilities.

What we have learned from our experience with the Community Support Program has confirmed that the chronically mentally ill need more than mental

health treatment alone. Because of their mental disabilities, they also need assistance in obtaining the other basic health and social services necessary for community life. This new concept, called a "community support system," was developed to describe the comprehensive system of care that chronically mentally ill persons need.

Our Agency's demonstration program has provided modest financial assistance to States to better coordinate and expand existing services in a variety of locales. At its inception in 1977, the Community Support Program provided support to State mental health agencies in 19 States and the District of Columbia. In 1982, an additional 19 new States and the Virgin Islands received support.

The CSP demonstration program has proven that there are effective methodologies for promoting collaboration among various levels of government and across the broad array of public and private health and human service agencies on behalf of the chronically mentally ill.

The subject of this Committee's hearing is an infinitely complex one. The term "street people" describes only their homelessness, not their condition nor the cause of their plight. Even the estimated 35 to 40 percent of homeless Americans who are suffering serious mental health, alcohol, or drug abuse problems are not a homogeneous group. Among them are those who have left mental institutions.

But evidence suggests that there may be an even greater and growing number of persons living on the street who have never been in mental institutions, yet who are seriously mentally ill. The mental health professions call them the "young adult chronics."

Moreover, many persons among the homeless do not meet the standard psychiatric criteria of being mentally ill, but act strange or eccentric. Some of these persons are not prepared to seek nor even to accept assistance from community caregivers. They have adopted the street, where they struggle to maintain some sense of freedom, as their preferred lifestyle.

I do not believe that any panacea or easy solution exists to the problem of the homelessness of so many mentally ill Americans.

It is true that we need accurate epidemiological data to develop flexible long-term strategies appropriate to the needs of individual States and localities.

But the Alcohol, Drug Abuse, and Mental Health Administration has already begun to explore ways in which our three Institutes can employ our limited resources and mandate. To further assist States and localities with this national problem, we are now planning to supplement a limited number of existing CSP grants with funds to permit States to design and evaluate comprehensive approaches to dealing specifically with chronically mentally ill persons who are homeless.

As a first step, we will ask grantees receiving supplements to conduct an analysis of the population and its needs. We shall also encourage collaboration with Federal, State, and local agencies in both public and private sectors to promote peoples' access to needed services such as medical and mental health treatment, shelter, food, clothing, employment, and other basic life supports. Finally, we plan to disseminate the experience gained from these projects so that service providers and policy makers everywhere may combine their much needed individual actions to help the forgotten people of our society whose home is the street.

INTRODUCTION OF ASSOCIATES

Dr. LEVINE. Mr. Chairman, I am here also to serve as a technical resource person to the subcommittee.

On my left side, your right side, is Mr. Neal Brown. Mr. Brown is the Assistant Branch Chief of the Community Support Program. It was my understanding that you were interested in the community support program, and he can act as a technical resource expert on that program.

Senator SPECTER. Fine.

Welcome, Mr. Brown.

Dr. LEVINE. In order to provide a context for the Federal role, more specifically the role of the Alcohol, Drug Abuse, and Mental Health Administration, I wanted to say that our mission is primarily one of research. To accomplish this mission we also offer some demonstration programs and attempt to disseminate information from these programs across the Nation. I should note that ADAMHA's mission has very recently changed with the advent of block grants. Prior to that, we were directly involved in services. However, in fiscal year 1982, we transferred \$432 million to the States through the block grant mechanism so that States now have the leverage to assure that local authorities and agencies provide mental health, drug abuse and alcohol services.

We try to do some data gathering at the national level, but we have found that it has been virtually impossible to provide accurate national data on homelessness. We do know that the homeless population is not a homogeneous one. It includes runaway children, immigrants, migrants, so-called bag ladies, the recently evicted, certain numbers of the unemployed, battered women, an overrepresentation of minorities, and persons with serious and persistent alcohol, drug abuse, and mental health problems.

Dr. LEVINE. Moreover, Mr. Chairman we found that this population varies from locality to locality. We are not talking about the same population in every area of the country. But, very conservatively, we estimate that at least 35 to 40 percent of the homeless population nationwide has alcohol, drug abuse and/or mental health disorders. We found higher statistics in some cities and lower in others.

I also agree with Dr. Arce, who made the comment that deinstitutionalization is not the same as homelessness. Deinstitutionalization may account for some portion of the problem of homelessness but only a small subpart of it. I was thinking through the causes of deinstitutionalization, how it happened, and how the Federal Government was involved in deinstitutionalization, and I would like to offer a few comments about that. These reflect my own opinion and experience, and do not necessarily reflect those of Dr. Mayer or the agency.

By way of background the introduction of psychotropic medications; the recognition of the values of community psychiatry; the adoption of open door policies; recent legal precedents that gave people the right to treatment in the least restrictive setting; and certain economic factors as well, for instance, the fact that hospitalization cost \$2 a day in 1950, and \$58 a day in 1977 gave States the motivation to deinstitutionalize their State hospitals quite rapidly.

At that time, in the 1960's, the community mental health centers movement began with the support of President Kennedy. Since that time the Federal Government has created a network of over 789 centers, at a cost of over \$2 billion.

I want to emphasize that the theory of deinstitutionalization is the only one that is humane, and that professionals still give credence to the theory. But there has been controversy and a lot of valid criticism over its implementation: the fact that the implementation of deinstitutionalization policy was not fully thought out or planned.

For instance, it was hoped that community mental health centers would be spread across the entire country. They were established in only 50 percent of the service areas in the country. One of the reasons for that was, I believe, the inflexibility of the legislation. Every center was required to have 5 essential services at start up, and later 12, and many communities just could not afford—

Senator SPECTER. Who imposed that fact, that criteria?

Dr. LEVINE. The law.

Senator SPECTER. And you felt those were too flexible?

Dr. LEVINE. It is my opinion that they were too inflexible for some communities. I do not think the people who developed them thought they would be. The law attempted to provide humane and comprehensive care, but it had flaws and centers were not set up all over the country.

The second thing that happened was that we transferred people from State hospitals, where they had a roof over their head, laundry service, food, and other necessary services, to a Community Mental Health Center. The Community Mental Health Center was only mandated to provide mental health treatment. The centers never had the mandate nor the funds to provide the other ancillary services that a chronically mentally ill person needs in a community.

Last, community mental health centers funds went directly from the Federal Government to the centers. State hospitals had the discharge responsibility for chronically mentally ill persons. There was very poor coordination between the community mental health centers and the State hospitals.

These are some of my personal observations of the problems in implementation of deinstitutionalization from the Federal perspective.

Today I know, Mr. Chairman, you are interested particularly in hearing a little bit about the community support program.

In 1977, the Federal Government began to gather information about the problems of the chronically mentally ill, and wanted to do something to address them. So we called in a working conference of leaders from the field, including researchers, academicians, union officials, professionals, and many others who were involved in the care of this population. From that meeting two things emerged.

One was that a conceptual framework was designed to describe what chronically mentally ill persons need in the community. This concept is called a "community support system," and it basically addresses the fact that there needs to be coordination at the client level, between the men-

tal health services and the other health and human services a mentally ill person needs in the community.

The second thing was that the Federal Government decided to develop a grant program to help States develop flexible models of community support systems at the local level. NIMH initially provided funds to 19 States and the District of Columbia, to develop model programs, and test out this new theory under a variety of circumstances.

Senator SPECTER. Now, what is that new theory?

Dr. LEVINE. The idea of a community support system. We are saying that chronically mentally ill patients need more than mental health treatment alone. They need housing, they need food, they need all the other services that you or I need to live.

Senator SPECTER. I notice from Dr. Mayer's prepared statement that there are between 1.5 and 2 million chronically mentally ill persons nationwide.

Dr. LEVINE. Yes.

Senator SPECTER. Is that the total number of all chronically mentally ill people out of the 230 some million who live in this country?

Dr. LEVINE. I think that is the best estimate. Some estimates have gone up to 2.4 million. It is a range, and we do not have precise figures.

Senator SPECTER. How many of these people would be street people, if you know?

Dr. LEVINE. It is very hard to estimate. The largest proportion of people who leave State hospitals return to their families. Whether or not families have the resources to cope with a problem like this, over 65 percent of discharged patients return to their families.

Senator SPECTER. I note that in his testimony. What about the other 35 percent?

Dr. LEVINE. Well, we are not quite sure. We know that some return to residential treatment settings that were described by the previous witnesses. Some patients are successful and live independently in the community, and some do become street people. We are not clear as to the precise number or proportion.

Senator SPECTER. Dr. Levine, in the estimate of 1.5 to 2 million that he described as chronically mentally ill, how would you define chronically?

Dr. LEVINE. The community support program definition of a chronically mentally ill person is a person whose disability is severe and persistent, but who does not require 24 hour nursing care.

Senator SPECTER. And if they did require 24 hour nursing care, how would they be defined?

Dr. LEVINE. They would also be defined as chronically mentally ill. However, if I had a relative that required inpatient hospitalization for a chronic mental illness, I would hope that that person could go to the acute psychiatric ward of a general hospital, receive care, and then go out into the community and resume their lives. For many people, these kinds of services are not available, and they wind up in State hospitals, which become very stigmatizing.

Once you have been in a State hospital, it is a label that stays with you for life.

Senator SPECTER. What is your evaluation as to how well the national effort is being handled on the so-called street people?

Dr. LEVINE. I guess at this point in time, I cannot really say in any honesty that there is a national effort. I want to commend you, Mr. Chairman, on beginning these hearings, I feel that investigating the matter is a big start. At the Alcohol, Drug Abuse, and Mental Health Administration, we are planning to supplement five of our CSP grants to begin working on the problem of homeless people who are chronically mentally ill. But we are only one Federal agency doing a very small part.

Senator SPECTER. What do you think ought to be done on a national level to get a handle on the problem of street people on a nationwide basis?

Dr. LEVINE. Well, I would hope that we could continue raising the consciousness of people that care within the Federal bureaucracy, and I hope that, for instance, our agency can begin working with other Federal agencies that can play a part in addressing this problem.

Senator SPECTER. Raising the consciousness of people who care? Would you care to identify them?

Dr. LEVINE. Bureaucrats care, citizens care, and the publicity that an issue like this receives is important in getting people to work together. It is a very, very complex problem, and its solution is just as complex.

Senator SPECTER. Mr. Buford, let us turn to you now, if we may. I know that you have served as director of the District of Columbia Department of Human Services for almost the past 3 years.

What do your duties involve, in a general way, Mr. Buford?

Mr. BUFORD. Would you repeat the question?

Senator SPECTER. What do your duties involve, in a general way?

Mr. BUFORD. The Department of Human Services has the responsibility for providing health and social services to District residents. Among these responsibilities include the delivery of a wide range of services, from the population that we are concerned with today, street people, homeless, those individuals who have been deinstitutionalized from our institutions.

Senator SPECTER. Mr. Buford, your full statement will be made a part of the record. We would appreciate it if you would summarize it.

Mr. BUFORD. I have a prepared statement, Mr. Chairman, and I will try to abbreviate it.

Senator SPECTER. All right.

Mr. BUFORD. I do not have a summary, per se. I just completed it on the way to the hearing.

The District of Columbia, like other States across the country, is being confronted with an increasing demand for emergency assistance.

Senator SPECTER. We had been provided with a document in which testimony of James A. Buford, director, which was denominated "draft." I take it you have revised that somewhat upon your way?

Mr. BUFORD. I have it with me.

Senator SPECTER. All right. Well, if you would make that available to us we will see that your statement in its final form is made a part of the record.

Mr. BUFORD. I will do that.

Senator SPECTER. You may proceed.

STATEMENT OF JAMES BUFORD

Mr. BUFORD. We think that there is a definite relationship between the population we are discussing and the shift in the philosophy of treating the mentally ill from custodial care in institutions to treat the same individuals through community based care, and resulting in what has been known and what has been discussed this morning as deinstitutionalization.

As is true with reform movements in general, one can argue the dehumanizing conditions that often exist inside mental hospitals, similarly, one can argue the plight of deinstitutionalized patients who are residing in the community. We have, however, come a long way in acknowledging a place for both institutional and community based care.

We do subscribe to community based care as the preferred locus of the least restrictive care and treatment of the mentally disabled, but with the full recognition that appropriate care can take place along the entire continuum from community to institution.

Initially, deinstitutionalization was considered a good thing with the assumption that community based care is more effective since the goal of treatment is to return persons to the community.

The movement toward community based care has been strongly encouraged by the mental health legislation. However, mental health litigation at times has forced the escalation of deinstitutionalization before the necessary continuum of treatment and support services were developed.

The District Government knows well the problems and costs associated with caring for the mentally ill in the face of litigation. However, we remain committed to providing the needed and most appropriate services to improve the quality of life for our vulnerable residents, for the mentally ill, and dedevelopmentally disabled.

In 1974, the Federal and District Governments were sued on behalf of William Dixon and others, to force the deinstitutionalization of patients from the federally-operated St. Elizabeth's Hospital for the Mentally Ill. To settle this suit, a plan was developed and accepted by the court in 1980. This plan committed the District to spend more than \$17 million and the Federal Government to more than \$16 million to implement the services which would cover, not only clients leaving the hospital, but all adult clients of the District's community mental health centers. This plan represents one of the Nation's most ambitious plans for insuring that clients of a public inpatient psychiatric facility are placed in appropriate community settings.

Deinstitutionalization has occurred, is occurring, and will continue to occur throughout the country for a combination of reasons. It is clear

that many people remaining in large impersonal institutional facilities could be better cared for in appropriately conceived and operated community programs. It is also clear that unless such facilities are developed, moving people out of institutions into a haphazard nonsystem of community settings is no solution. It is possible for poorly planned placements in the community to be just as inappropriate as placements in large institutions.

A GAO report entitled, "Returning The Mentally Disabled to the Community Could Do More," currently identified the major problems of current deinstitutionalization efforts:

Many mentally disabled persons have been released from institutions before sufficient community facilities and services were available, and without adequate planning and followup.

Many persons remain in, continue to enter, or reenter institutions primarily because appropriate community services do not exist or are not readily accessible.

Many persons have been placed in community settings which are not appropriate to their needs, again primarily because more relevant settings and services are not currently available.

While these deficiencies are legitimate and well stated, they should not be construed as detracting from what should be a continuing and accelerated emphasis on developing community based service systems.

The deinstitutionalization movement nationwide must take steps to become more responsive to the needs of patients to be fulfilled in community settings. Three very positive goals which essentially follow from the problems identified by the GAO report are:

To provide full and equal opportunities for the mentally ill. Priority attention is being given to efforts to eliminate policies and practices from existing Federal programs such as medicaid, medicare, SSI, housing, social services, and vocational rehabilitation, which serve as obstacles, making it difficult for people to get the entitlements for which they are eligible. Without special efforts of this kind, people with mental health problems will continue to fall through the cracks, and may become homeless street people.

A second major goal is the development of comprehensive community support systems for people with mental health problems, assuring the population at risk that their needs will be met in an appropriate setting.

Third, improving the quality and relevance of services to people with mental disabilities, whether such services are provided in institutions or in the community.

Senator SPECTER. Director Buford, how well are those objectives being realized at the present time, in the District of Columbia, in your judgment?

Mr. BUFORD. In my opinion, these objectives are—we are making substantial progress in achieving these objectives.

Senator SPECTER. How many street people would you say there are in the city of Washington?

Mr. BUFORD. We estimate approximately 2,000.

Senator SPECTER. You disagree with Mr. Snyder's estimate of 5,000 to 10,000?

Mr. BUFORD. I have not heard his testimony.

Senator SPECTER. He testified earlier this morning that he thought there were 5,000 to 10,000 street people.

Mr. BUFORD. We estimate approximately 2,000.

Senator SPECTER. And how many of those 2,000 do you think are being adequately cared for?

Mr. BUFORD. We have a capacity in the facilities that we use to treat homeless men and women, approximately 400 to 500 beds, and the occupancy during the colder nights, for the last 2 weeks, in many instances, have been less than 100 percent. I cannot tell you of how many of the 1,500 are being adequately cared for, but to the extent that they present themselves to the facilities that they occupy, we provide the services that they require.

Senator SPECTER. So you are saying that there is more space, more beds available than there are street people who need those accommodations?

Mr. BUFORD. I am saying that the facilities that we occupy are not occupied on the colder nights, 100 percent.

Senator SPECTER. And?

Mr. BUFORD. Consistently.

Senator SPECTER. Are there people who simply do not know about them, or are all of the street people not being accommodated? Are you saying that some of the street people do not know about them, or some of the street people prefer to be on the street, even though a bed is available?

Mr. BUFORD. I think there are many reasons. I think we have done a reasonably good job informing the public of the location of the facilities that we occupy, that we operate, we also provide transportation, that cruise the D.C. area generally, in order to pick up individuals who express an interest in going to the facilities.

So, in many instances, as we canvass the District, and as we identify individuals who appear to need shelter, and we offer that shelter, it is not always accepted.

Senator SPECTER. Mr. Buford, Mr. Snyder testified earlier this morning that people are put out of the city shelters at 5:50 in the morning. Is that accurate, according to your knowledge?

Mr. BUFORD. Seven o'clock is the time.

Senator SPECTER. Seven o'clock?

Mr. BUFORD. That is when we begin to move the individuals out of the communities.

Senator SPECTER. And why is that hour selected?

Mr. BUFORD. I think the program has a responsibility for providing services that are required during the time that they are needed.

Senator SPECTER. Well, is 7 a.m. a little early? Is it still dark? It was dark this morning.

Mr. BUFORD. After breakfast is provided.

Senator SPECTER. What time is breakfast provided?

Mr. BUFORD. I have with me our program specialist, who does manage the shelters, and can answer some of these questions more directly.

Senator SPECTER. Fine.

What is your name, sir?

Mr. GLOVER. Bruce Glover. I work as a special assistant to Audrey Rowe, commissioner of social services.

Most of the men do leave at 7 o'clock, to attend, so that others may eat breakfast. On the coldest night we have a contract with the Council of Churches. On the colder days many are left in the facilities 24 hours. Whenever the temperature goes down below 32 degrees, we do have them stay in the building.

Mr. Snyder made reference probably to Bundy School. We had informed the residents of the Shaw community, and for the Bundy School, that we would bus the people out of the community at 7 o'clock. This was a compromise that we made with the community so that we could resolve that.

Senator SPECTER. That was as a result of community pressure, you are saying?

Mr. GLOVER. Yes.

Senator SPECTER. So actually, what time are they compelled to leave?

Mr. GLOVER. At 7 o'clock they are compelled to leave from one school, and they are bused from that school to the shelter, where they eat. If they wish to have daytime shelter, then we would continue to go to Blair on colder nights. But as a rule, we generally close the shelter at 7 during the wintertime.

Senator SPECTER. Are you familiar with the story in this morning's Post, captioned Freddie dies?

Mr. GLOVER. Yes; I am.

Senator SPECTER. Do you know the circumstances surrounding that situation, as to whether—

Mr. GLOVER. From what I understand—

Senator SPECTER. Whether he was compelled to leave the shelter?

Mr. GLOVER. From what I understand, this gentleman, Freddie, did stay at Bundy School a couple of nights prior to his death.

The reason that he refused to go back, he said, was because the people forced him to leave at 5 o'clock. To the best of my knowledge, everyone left between 6:30 and 7 o'clock.

Senator SPECTER. You said 6:30 and 7 o'clock?

Mr. GLOVER. Yes; the men, to be awakened at 6:15. The building is generally cleared at Bundy School at 7 o'clock, on cold days the shelter stays open 24 hours, on a 24-hour basis. Freddy—and I have not—from talking to other people, from what I can understand, had gone on a binge.

One of the problems that we do have is that a lot of people who do refuse, the people are mentally ill, and we cannot force those individuals to come into shelters.

Senator SPECTER. Was that response relative to Freddie's case?

Mr. GLOVER. From what I understand, I do not see the reasoning. Most of the people do leave at 7 o'clock. The purpose of the emergency shelter, such as Bundy, is to keep people from dying on the street. So we do have a facility open at night so people will not have to sleep in phone booths, or out in cardboard boxes.

If he stayed one night, if he had to be bused to get something to eat, I think it would have been more beneficial to him to spend the night, which is the coldest part of the day, in a shelter.

Senator SPECTER. Well, was he bused some place to get something to eat?

Mr. GLOVER. He would have been bused with the other gentlemen to go. The other gentlemen do have their agendas, and wherever they please.

Senator SPECTER. And if they choose to be bused somewhere to eat, where would they go?

Mr. GLOVER. They would be bused to O and First Street, which is the SOME soup kitchen, which is an acronym, so others may eat.

Senator SPECTER. Director Buford, did you hear the testimony of Reverend Nees, concerning the U.S. Marshals being paid by landlords to evict people?

Mr. BUFORD. I did not hear the testimony. I am familiar with the evictions that took place sometime ago.

Senator SPECTER. Is it true that the U.S. Marshals were paid for their overtime service by landlords for evictions on weekends?

Mr. BUFORD. It is my understanding that the association, Landlord Association, did pay for the overtime involved in serving some of the evictions.

Senator SPECTER. Has that now been discontinued?

Mr. BUFORD. It is my understanding that it has been discontinued.

Senator SPECTER. Is that regarded as a lawful approach? The problem I see with it, is that the marshals are supposed to be objective in the terms of the execution of the court order, and that is difficult to do if they are being paid by the people who have a pecuniary financial interest.

Mr. BUFORD. I assumed that it was legal. We certainly have no responsibility for that aspect of the system.

Senator SPECTER. Your responsibilities do not encompass that in any way?

Mr. BUFORD. No; it does not. We have responsibility for assisting the families that are evicted. And on Saturdays and Sundays, most of the social service agencies that have the resources to assist these families, once they are evicted, are closed, and as long as it is during the week, we certainly can be resourceful in assisting the families to relocate.

Senator SPECTER. So that would be another reason for not having evictions on the weekends. Your facilities are not geared up to handle a service issue at that time?

Mr. BUFORD. Not in the numbers that began to take place, because of abuse of large numbers of convictions.

Senator SPECTER. What more, if anything, should be done, Director Buford, in your opinion, to help with the problem of the street people in the District of Columbia?

Mr. BUFORD. I think that we have a tremendous problem with providing the range of services that we provide to some 100,000 people in the District, which not only includes the street people, but which includes the most vulnerable residents in the District, among which includes the street people.

To the extent that resources are available, we are doing everything that we can for the 106,000 residents, and I think that—

Senator SPECTER. What additional resources would you like to have available?

Mr. BUFORD. What additional resources?

Senator SPECTER. You say "to the extent that resources are available." I understand that answer.

But my inquiry is—what more should be done, in your judgment, directing yourself to the street people, at this time?

Mr. BUFORD. I think there should be more employment opportunities, in order for the individual to become gainfully employed, and to become self-sufficient.

Senator SPECTER. Do you think the street people would be able to undertake a job?

Mr. BUFORD. No question about it. The article that you read in this morning's paper, the article that you read in yesterday morning's paper, indicated that a large number of people who are now on the streets, who are on the streets only because they cannot find employment, we are not talking about necessarily individuals who have been on the street for years. We are talking about individuals who have been there for months or weeks or days. We are talking about housing, providing housing opportunities for individuals.

Senator SPECTER. Director Buford, how many of the street people would you estimate could handle jobs if they were available?

Mr. BUFORD. I do not know.

Senator SPECTER. Could you give me an estimate, half, a third? A quarter, two-thirds?

Mr. BUFORD. About a fourth.

PREPARED STATEMENT

Senator SPECTER. Director Buford, Dr. Levine, thank you very much for joining us here today. We very much appreciate your testimony.
[The statement follows:]

STATEMENT OF JAMES A. BUFORD

MY NAME IS JAMES A. BUFORD, I AM DIRECTOR OF THE DEPARTMENT OF HUMAN SERVICES OF THE DISTRICT OF COLUMBIA. THE DEPARTMENT IS RESPONSIBLE FOR PROVIDING HEALTH AND SOCIAL SERVICES TO DISTRICT RESIDENTS. INCLUDED IN THIS RESPONSIBILITY IS A PROVISION OF A COMPREHENSIVE RANGE OF SERVICES FOR THE POPULATION THIS SUBCOMMITTEE IS CONCERNED WITH -- THE "STREET PEOPLE" - "THE HOMELESS" - PEOPLE WHO HAVE BEEN DEINSTITUTIONALIZED FROM OUR INSTITUTIONS.

THE DISTRICT OF COLUMBIA LIKE OTHER STATES ACROSS THE COUNTRY IS BEING CONFRONTED WITH AN INCREASING DEMAND FOR EMERGENCY ASSISTANCE IN THE FORM OF FOOD, SHELTER, CLOTHING AND FINANCIAL ASSISTANCE - THE DEMANDS ARE BEING MADE BY AN INCREASING NUMBER OF MEN, WOMEN AND FAMILIES WHO FOR MANY REASONS HAVE BECOME DEPENDENT ON THE PUBLIC AND PRIVATE SECTOR FOR SURVIVAL.

WE DO BELIEVE THERE ARE HUNDREDS OF MEN AND WOMEN WHO ARE AT RISK IF THEY DO NOT GET SHELTER AND WE DO OUR BEST TO SEEK THEM OUT, PROVIDE THAT SHELTER AND MORE IMPORTANTLY, PUT THEM IN TOUCH WITH FAMILIES WHO ARE SEARCHING FOR THEM. WHERE THEY HAVE NO FAMILIES WE TRY TO CONNECT THEM WITH SOCIAL SERVICES TO WHICH THEY MAY BE ENTITLED. OUR SHELTER PROGRAM, IN FACT, EMPLOYS A NUMBER OF MEN WHO WERE THEMSELVES HOMELESS ONCE. THEY JOINED OUR STAFFS AFTER RECEIVING THE CARE,

TRAINING AND HELP THEY NEEDED. THEY KNOW THE PROBLEMS OF THE HOMELESS AND THEY ARE EMINENTLY SUITED TO CARE FOR THEM.

INTRODUCTION

THERE IS A DEFINITE RELATIONSHIP BETWEEN THE POPULATION WE ARE DISCUSSING AND THE SHIFT IN THE PHILOSOPHY OF TREATING THE MENTALLY ILL FROM CUSTODIAL CARE IN INSTITUTIONS TO TREATMENT THROUGH COMMUNITY-BASED CARE - AND RESULTING IN WHAT HAS COME TO BE KNOWN AS DEINSTITUTIONALIZATION IS CLEARLY, AN UNSETTLED ISSUE. WHILE THIS HEARING MAY REASONABLY BE EXPECTED TO BRING SOME CLARITY TO THE ISSUES OF THE HOMELESS AND THE PROBLEMS OF DEINSTITUTIONALIZATION, MUCH DISCUSSION WILL ENSUE LONG AFTER THIS HEARING IS OVER.

AS IS TRUE WITH REFORM MOVEMENTS IN GENERAL, ONE CAN ARGUE THE DEHUMANIZING CONDITIONS THAT OFTEN EXIST INSIDE MENTAL HOSPITALS - SIMILARLY, ONE CAN ARGUE THE DAMNING PLIGHT OF DEINSTITUTIONALIZED MENTAL PATIENTS WHO ARE RESIDING IN THE COMMUNITY. WE HAVE, HOWEVER, COME A LONG WAY IN ACKNOWLEDGING A PLACE FOR BOTH INSTITUTIONAL AND COMMUNITY-BASED FACILITIES.

I DO SUBSCRIBE TO COMMUNITY-BASED CARE AS THE PREFERRED LOCUS OF LEAST RESTRICTIVE CARE AND TREATMENT OF THE MENTALLY DISABLED, BUT WITH THE FULL RECOGNITION THAT APPROPRIATE CARE

CAN TAKE PLACE ALONG THE ENTIRE CONTINUUM FROM COMMUNITY TO INSTITUTION.

DEINSTITUTIONALIZATION DEFINED

INITIALLY, DEINSTITUTIONALIZATION WAS CONSIDERED A "GOOD THING" WITH THE ASSUMPTION THAT COMMUNITY-BASED CARE IS MORE EFFECTIVE SINCE THE GOAL OF TREATMENT IS TO RETURN PERSONS TO THE COMMUNITY.

THE MOVEMENT TOWARD COMMUNITY-BASED CARE HAS BEEN STRONGLY ENCOURAGED BY MENTAL HEALTH LEGISLATION. HOWEVER, MENTAL HEALTH LITIGATION AT TIMES HAS FORCED THE ESCALATION OF DEINSTITUTIONALIZATION BEFORE THE NECESSARY CONTINUUM OF TREATMENT AND SUPPORT SERVICES WERE DEVELOPED.

THE DISTRICT GOVERNMENT KNOWS WELL, THE PROBLEMS AND COSTS ASSOCIATED WITH CARING FOR THE MENTALLY ILL IN THE FACE OF LITIGATION. HOWEVER, WE REMAIN COMMITTED TO PROVIDING THE NEEDED AND MOST APPROPRIATE SERVICES TO IMPROVE THE QUALITY OF LIFE FOR OUR VULNERABLE RESIDENTS. FOR THE MENTALLY ILL AND DEVELOPMENTALLY DISABLED, WE HAVE COMMITTED MILLIONS OF DOLLARS FOR THEIR CARE.

IN 1974, THE FEDERAL AND DISTRICT GOVERNMENTS WERE SUED ON BEHALF OF WILLIAM DIXON, ET. AL. TO FORCE THE DEINSTITUTIONALIZATION OF PATIENTS FROM THE FEDERALLY OPERATED SAINT ELIZABETHS

HOSPITAL FOR THE MENTALLY ILL. TO SETTLE THIS SUIT, A PLAN WAS DEVELOPED AND ACCEPTED BY THE COURT IN 1980. THIS PLAN COMMITTED THE DISTRICT TO SPEND MORE THAN \$17 MILLION AND THE FEDERAL GOVERNMENT TO MORE THAN \$16 MILLION TO IMPLEMENT THE SERVICES WHICH WOULD COVER, NOT ONLY CLIENTS LEAVING THE HOSPITAL, BUT ALL ADULT CLIENTS OF THE DISTRICT'S COMMUNITY MENTAL HEALTH CENTERS. THIS PLAN REPRESENTS ONE OF THE NATION'S MOST AMBITIOUS PLANS FOR ENSURING THAT CLIENTS OF A PUBLIC INPATIENT PSYCHIATRIC FACILITY ARE PLACED IN APPROPRIATE COMMUNITY SETTINGS.

DEINSTITUTIONALIZATION HAS OCCURRED, IS OCCURRING, AND WILL CONTINUE TO OCCUR THROUGHOUT THE COUNTRY FOR A COMBINATION OF REASONS. IT IS CLEAR THAT MANY PEOPLE REMAINING IN LARGE IMPERSONAL INSTITUTIONAL FACILITIES COULD BE BETTER CARED FOR IN APPROPRIATELY CONCEIVED AND OPERATED COMMUNITY PROGRAMS. IT IS ALSO CLEAR THAT UNLESS SUCH FACILITIES ARE DEVELOPED, MOVING PEOPLE OUT OF INSTITUTIONS INTO A HAPHAZARD NON-SYSTEM OF "COMMUNITY" SETTINGS IS NO SOLUTION. IT IS POSSIBLE FOR POORLY PLANNED PLACEMENTS IN THE COMMUNITY TO BE JUST AS INAPPROPRIATE AS PLACEMENTS IN LARGE INSTITUTIONS.

A GAO REPORT ENTITLED, RETURNING THE MENTALLY DISABLED TO THE COMMUNITY: GOVERNMENT COULD DO MORE (1977), CORRECTLY

IDENTIFIED THE MAJOR PROBLEMS OF CURRENT DEINSTITUTIONALIZATION EFFORTS:

- MANY MENTALLY DISABLED PERSONS HAVE BEEN RELEASED FROM INSTITUTIONS BEFORE SUFFICIENT COMMUNITY FACILITIES AND SERVICES WERE AVAILABLE, AND WITHOUT ADEQUATE PLANNING AND FOLLOW-UP.
- MANY PERSONS REMAIN IN, CONTINUE TO ENTER, OR REENTER INSTITUTIONS PRIMARILY BECAUSE APPROPRIATE COMMUNITY SERVICES DO NOT EXIST OR ARE NOT READILY ACCESSIBLE.
- MANY PERSONS HAVE BEEN PLACED IN "COMMUNITY" SETTINGS WHICH ARE NOT APPROPRIATE TO THEIR NEEDS, AGAIN PRIMARILY BECAUSE MORE RELEVANT SETTINGS AND SERVICES ARE NOT CURRENTLY AVAILABLE.

WHILE THESE DEFICIENCIES ARE LEGITIMATE AND WELL STATED, THEY SHOULD NOT BE CONSTRUED AS DETRACTING FROM WHAT SHOULD BE A CONTINUING AND ACCELERATED EMPHASIS ON DEVELOPING COMMUNITY-BASED SERVICE SYSTEMS.

GOAL FORMULATION

THE DEINSTITUTIONALIZATION MOVEMENT NATIONWIDE MUST TAKE STEPS TO BECOME MORE RESPONSIVE TO THE NEEDS OF PATIENTS TO BE FULFILLED IN COMMUNITY SETTINGS. THREE VERY POSITIVE

GOALS WHICH ESSENTIALLY FOLLOW FROM THE PROBLEMS IDENTIFIED BY THE GAO STUDY.

GOAL ONE:

TO PROVIDE FULL AND EQUAL OPPORTUNITIES FOR THE MENTALLY ILL. PRIORITY ATTENTION IS BEING GIVEN TO EFFORTS TO ELIMINATE POLICIES AND PRACTICES FROM EXISTING FEDERAL PROGRAMS SUCH AS MEDICAID, MEDICARE, SSI, HOUSING, SOCIAL SERVICES AND VOCATIONAL REHABILITATION. WHICH SERVE AS OBSTACLES MAKING IT DIFFICULT FOR PEOPLE TO GET THE ENTITLEMENTS FOR WHICH THEY ARE ELIGIBLE. WITHOUT SPECIAL EFFORTS OF THIS KIND, PEOPLE WITH MENTAL HEALTH PROBLEMS WILL CONTINUE TO FALL THROUGH THE "CRACKS" AND MAY BECOME HOMELESS STREET PEOPLE.

GOAL TWO:

A SECOND MAJOR GOAL IS THE DEVELOPMENT OF COMPREHENSIVE COMMUNITY SUPPORT SYSTEMS FOR PEOPLE WITH MENTAL HEALTH PROBLEMS— ASSURING THE POPULATION AT RISK THAT THEIR NEEDS WILL BE MET IN AN APPROPRIATE SETTING.

GOAL THREE:

IMPROVING THE QUALITY AND RELEVANCE OF SERVICES TO PEOPLE WITH MENTAL DISABILITIES - WHETHER SUCH SERVICES ARE PROVIDED IN INSTITUTIONS OR IN THE COMMUNITY. INSTEAD OF FOCUSING

ATTENTION ON HOW MANY PEOPLE CAN BE MOVED FROM ONE SETTING TO ANOTHER, THERE IS A CRITICAL NEED TO ASSESS AND IMPROVE THE NATURE AND QUALITY OF THE ENVIRONMENTS IN WHICH THEY ARE PLACED AND THE SERVICES THEY RECEIVE.

CRITICAL SHORTAGE AREAS

A PERVASIVE AND RECURRENT THEME IS THE CRITICAL SHORTAGE OF ADEQUATE AND APPROPRIATE COMMUNITY FACILITIES AND SERVICES FOR PEOPLE WITH MENTAL DISABILITIES. AMONG THOSE MOST FREQUENTLY CITED AS LACKING BUT WHICH THE DISTRICT HAS PROVIDED FOR, ARE THE FOLLOWING:

- CLEARLY DEFINED CASE MANAGEMENT SERVICES WHICH ASSURE THAT THE POPULATION AT RISK IS IDENTIFIED, THEIR NEEDS ARE ASSESSED, AND ARRANGEMENTS ARE MADE TO MEET THOSE NEEDS.
- OUTPATIENT MENTAL HEALTH SERVICES.
- EMERGENCY AND CRISIS SERVICES ON CALL 24 HOURS A DAY, SEVEN DAYS A WEEK.
- DAY PROGRAMS WHICH PROVIDE TRAINING IN COMMUNITY LIVING AS WELL AS SOCIAL AND/OR VOCATIONAL OPPORTUNITIES.

- REHABILITATIVE LIVING ARRANGEMENTS FOR PEOPLE MAKING A TRANSITION TO A HIGHER LEVEL OF INDEPENDENCE.
- LONG TERM SUPPORTIVE LIVING ARRANGEMENTS FOR PEOPLE WHO NEED SOME DEGREE OF SUPPORT OR SUPERVISION, BUT DO NOT REQUIRE TOTAL INSTITUTIONAL CARE.
- VOCATIONAL REHABILITATION SERVICES.
- LONG-TERM SHELTERED EMPLOYMENT OPPORTUNITIES.

CONCLUSION

FOCUSING ON THE PROBLEMS OF THE DEINSTITUTIONALIZATION PROCESS IS A NECESSARY STEP IN BRINGING TO THE SURFACE THOSE FACTORS WHICH MUST ^{BE} ADDRESS^AED IF OUR GOAL IS TO BE ACHIEVED. OUR AGENDA FOR THE FUTURE MUST INCLUDE THE FOLLOWING:

1. THE DEVELOPMENT OF A SYSTEMATIC APPROACH TO FINANCING COMMUNITY-BASED SERVICES WHICH PROVIDE FOR:
 - A) DEVELOPING COMMUNITY ALTERNATIVES WHILE AT THE SAME TIME MAINTAINING ^{THE} QUALITY OF HOSPITAL PROGRAMS FOR THOSE WHO NEED THEM;

- B) ADEQUATE AND STABLE METHODS FOR FINANCING
COMMUNITY MENTAL HEALTH PROGRAMS; AND,
 - C) APPROPRIATE UTILIZATION OF CURRENTLY AVAILABLE
FEDERAL RESOURCES.
3. THE COMMITMENT OF "MAINSTREAM" HUMAN SERVICE AGENCIES
TO PROVIDING NEEDED RESOURCES AND SERVICES FOR
MENTALLY DISABLED PERSONS.
 4. ESTABLISHING ADEQUATE AND EFFECTIVE METHODS FOR
ASSURING QUALITY AND APPROPRIATENESS OF COMMUNITY
SERVICES.
 5. FACILITATING COORDINATION BETWEEN MENTAL HOSPITALS
AND COMMUNITY MENTAL HEALTH AND HUMAN SERVICE PROGRAMS.
 6. DETERMINING THE MOST APPROPRIATE LEVEL OF RESPONSIBILITY FOR FUNDING, DEVELOPING, OPERATING AND
MONITORING COMMUNITY-BASED SERVICES (FEDERAL, STATE
AND LOCAL).

WHILE WE ARE COMMITTED TO DEINSTITUTIONALIZATION, WE KNOW THAT FOR IT TO WORK, THERE MUST BE A PLANNED STRATEGY ON ALL LEVELS, INVOLVING THE GOVERNMENTS, THE COURT AND THE COMMUNITY-AT-LARGE. THIS STRATEGY MUST INCLUDE A REAL AND ATTAINABLE ACTION PLAN THAT OVER A DESIGNATED PERIOD OF TIME INCLUDES BOTH THE FISCAL RESOURCES AND THE FLEXIBILITY TO CHANGE, TO ACHIEVE

MAXIMUM, QUALITY RESULTS. WITHOUT IT, THE BEST OF PLANS, WILL LIMP ALONG. LIKEWISE, CONTINUOUS COURT ORDERS, IN AND OF THEMSELVES, DO NOT, AND CANNOT ENSURE SUCCESS, BUT MERELY STRAIN AND DEplete THE STATE'S CURRENT MEAGER RESOURCES AND FURTHER COMPLICATE IMPLEMENTATION OF THE PLAN. SIMILARLY, THESE COURT ORDERS FAIL TO RECOGNIZE THE MANY OTHER UNCONTROLLABLE DEMANDS ON THE STATE'S RESOURCES AND CONSEQUENTLY, OPEN A DOOR THAT HAS NO HINGES. UNLESS THE COURTS RECOGNIZE THE DYNAMICS OF GOVERNMENTS, THE EVERCHANGING ECONOMIC CONDITIONS AND THE SHIFTS IN COMMUNITY AND PROFESSIONAL ATTITUDES, IT MAKES NO SENSE TO CONTINUE ORDERS -- WHICH CAN PLACE VULNERABLE PEOPLE IN EVEN MORE VULNERABLE SITUATIONS.

THESE ISSUES ARE FUNDAMENTAL AND MUST BE EFFECTIVELY ADDRESSED IF WE ARE TO ACHIEVE A HUMANE AND EFFECTIVE TRANSITION TO COMMUNITY-BASED SERVICES SYSTEMS.

CONCLUSION OF HEARING

Senator SPECTER. That concludes all of our schedule of witnesses, so the subcommittee is now recessed.

[Whereupon, at 12:30 p.m., Monday, January 24, the hearing was concluded, and the subcommittee was recessed, subject to the call of the Chair.]

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